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Part I

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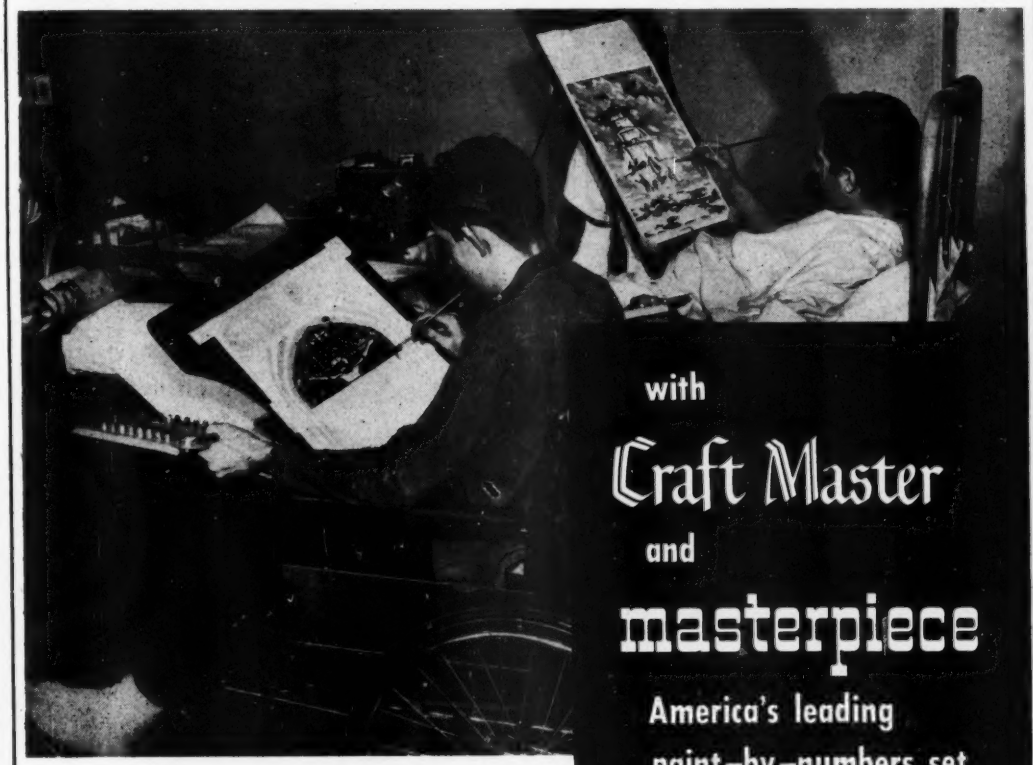

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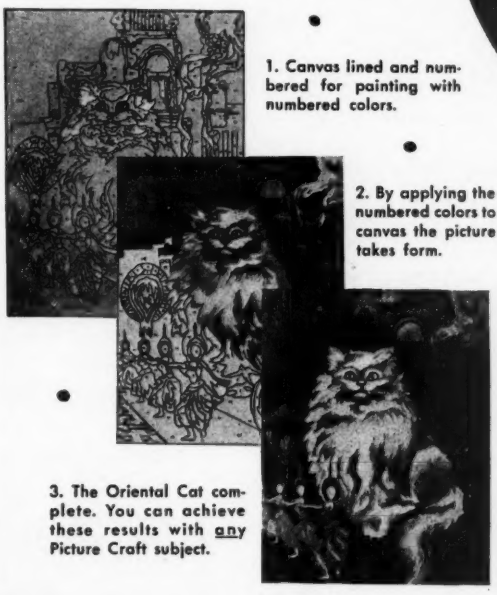

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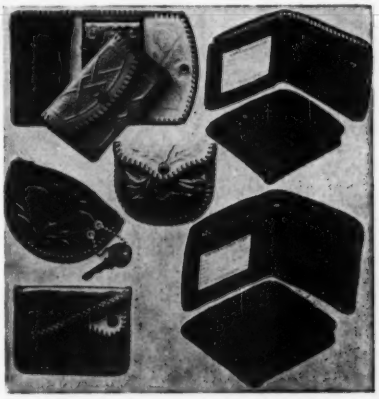

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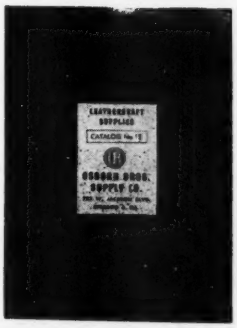

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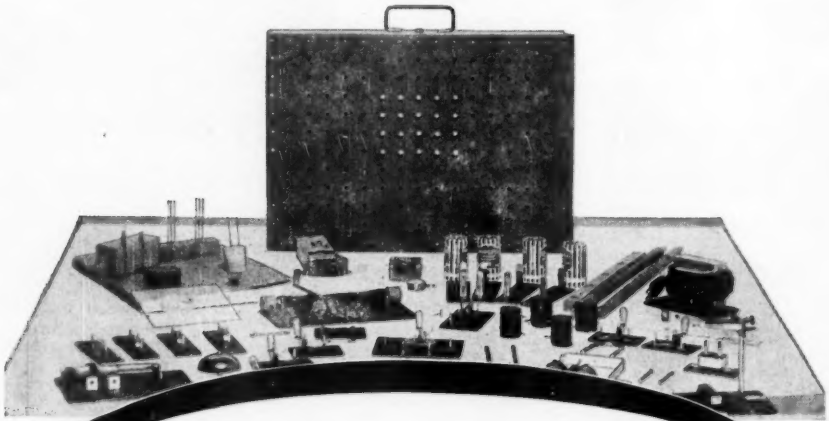

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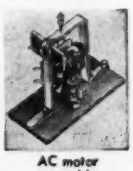

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REFINING OUR RESOURCES*

BEN L. BOYNTON, M.D.[1]

Occupational therapy plays an indispensable part in the restoration of people who, because of accident or illness, have become patients. The major theme of the annual conference of the American Occupational Therapy Association is "Refining Our Resources." What are our resources and what are the steps in the refining process?

The ultimate resource toward which we all look and to which our therapeutic efforts are directed is the patient. In what way is the patient a resource? First, we have no work to be done if the patient is not our center of focus. Occupational therapy per se has no intrinsic value; its value is manifested through the results achieved by the patient.

Second, we learn about people and perfect our skills by intelligent observation of the patient's response to the therapeutic activities with which we confront and sometimes confound him.

Third, our growth, both individually and collectively, is dependent upon the patient and the increasing needs which must be met if the restoration of the person is to be successful. It is natural for us to become imbued with our own importance and to feel that our work is the most significant. However, let us remind ourselves periodically and frequently that the patient is our major resource, the alpha and omega of occupational therapy.

There are several other resources which are important and which we all recognize, as for example: space, equipment, adequate personnel, proper training and supervision—to mention only a few. In the interest of time, however, let us examine only one other resource and that is *ourselves.* What are the most important contributions we can make? How can we refine our activities to achieve the most productive result? What are the steps in the refining process? One of the great sages has said: "Know thyself." To know one's self is certainly a major step in the refining process; we must also know ourselves in relation to our patients.

Let us pause a moment and look at the petroleum industry to see what some of the steps are in refining the "black gold" so generously supplied by Mother Earth. The crude oil as it comes from the well is a rather useless substance with little lubricating or fuel value. By a series of costly and complicated refining processes it is broken down into a vast array of useful products which range from paraffin for jelly glasses to high octane fuel for various aircraft engines. The unsung heroes of these refining operations are the catalysts. What are catalysts? What do catalysts do?

"What a Catalyst Is:

Catalysts are materials which change the speed or direction of a chemical reaction without being permanently changed themselves. They can be either gases, liquids or solids. Vitamins and enzymes are catalysts for body processes. Various metals and minerals are catalysts used in the petroleum and chemical industries."

"What a Catalyst Does:

A catalyst helps to change one substance into another substance. Industry uses catalysts to make better products such as making a good gasoline out of a poor one. The catalyst helps to do this by speeding up or directing the chemical reaction which makes the better product."*

*From Texaco Oil Co. placards

*Read at the 36th annual conference of the American Occupational Therapy Association, Houston, Texas, November, 1953.

1. Medical Director, Rehabilitation Institute of Chicago, 401 East Ohio Street, Chicago 11, Illinois.
Chairman of the Department and Professor of Physical Medicine, Northwestern University Medical School.

Note that catalysts, while entering into the reaction, are *not* permanently changed themselves. A principle of catalytic action is that though they assist in bringing about the desired change in compounds, they do not become a part of the end products. However some of the catalyst is consumed while the rest is recovered and used again.

Here we have an analogue of the function of occupational therapists as they assist in the recovery process of patients. The therapist obviously enters into the "reaction"; in his absence the process may be considerably slowed or, in some instances, may not proceed at all. He does not become a part of the final product but some of *him* is consumed in the process. He is not permanently changed and may be "used" repeatedly in similar operations. It is at this point that our analogy breaks down; catalysts are inorganic substances, while therapists are a mixture of inorganic, organic, temperamental and, withal, highly sensitive and sensible people. Also "therapeutic catalysts" subtly but definitely change over the years with increasing skill and understanding, this process is one of maturation about which we shall have further discussion. (In the petroleum industry reference is made to "cat crackers"—meaning catalytic stills which "crack" crude oil into numerous refinements. Some therapists may be "cats" in the area of interpersonal relationships, but such characteristics do not play a positive role in their professional effectiveness).

Examples of chemical catalysts are aluminum chloride, aluminum silicate and platinum. There are likewise different types of occupational therapists, i. e., those who are skillful in developing good interpersonal relationships with neuropsychiatric patients; those whose talents are most evident in working with brain-injured children; and those who are the ingenious gadgeteers who seem to have a limitless supply of useful adaptive devices to assist the disabled patient in achieving independence.

There are varying theories as to the exact mode of action of different catalysts; the fact that the full and complete story is not always known does not invalidate the use of these important chemical expeditors. It should not seem strange to us, therefore, that in the therapeutic field we may not always be able to analyze our steps in the successful or unsuccessful approach to the problems of any given patient. In fact it will be rarely that we can "pin point" this or that device as being the right or the wrong thing. Refinement of our resources must of a necessity be in the area of understanding persons—ourselves and those with whom or on whom we work.

The first step in the refining process is to recognize our role for what it is: we are essential to the process; we give of ourselves but we do not become a part of the finished product. Ours is essentially a catalytic relationship. We encourage the patient to respond and, to more or less degree, may have a part in the direction and extent of the patient's response. We cannot properly become a part of the end result by virtue of the fact that our goal for the patient is to make him independent of us. Should dependency develop we have defeated our own purpose. Dependency on us is permissible during the recovery process but is not desirable as the treatment periods draw closer to termination.

Second, we should strive consistently to profit by our experience—the period of training is the basic or primary experience, while the day-to-day work will broaden and enrich our knowledge if we will discipline ourselves to keep an open mind alert for new concepts. This discipline also requires a willingness to discard previous ideas when we recognize them to be less effective or definitely a hindrance to our work. The growing and effective therapist will never settle into a rut. The mature individual is one who *learns by doing*. It is worth noting here that two individuals may each have worked twenty years. The immature person may well have had one year's experience repeated twenty times, while the mature therapist is twenty times richer in productive experience.

Third, we are under obligation to be intellectually honest even though it offends our self-esteem. If, for example, we awake to the realization that we dislike a certain patient we should ask ourselves several questions: Is this dislike due to our own sense of inadequacy in understanding the patient? Is it due to some old prejudice which may have started in childhood and foments a negative attitude through our subconscious? Is it because we are too lazy to expend the energy necessary to get the job done? Is it related to preoccupation with personal or family problems which we are inadvertently projecting upon the hapless patient? In this connection let us look again at the chemical catalysts—it is necessary to "treat" these agents from time to time in order to retain their efficiency. So it is with us—we need to take time off in order to renew our vigor. We need to break the daily routine by attending professional conferences such as this convention to broaden our vision and to give us renewed inspiration to go on with our work. A subtle form of intellectual dishonesty is evident when we permit ourselves to feel that we are indispensable and cannot take time out for vacations or other non-routine activities. Of course we all need to feel that we are necessary and our work *is* important. However it is intellectual chicanery if we conclude that the world cannot possibly get along without us.

What about the steps in the refining process as related to those with whom we work—our patients? *First,* are we aware of the patient's point of view? Are we able to step back and look at the situation through the patient's eyes? Obviously we can never fully see through the patient's own visual apparatus, but by practical empathy (the attempt to see things as the other person views them) we will have made significant progress in understanding our patient. For example, we may be disgustingly familiar with our occupational therapy shop, but to the patient who comes for his first visits his experience may be quite confusing. A simple way of demonstrating this to yourself is to rearrange the furniture in your own living room and then attempt to dash through the room in total darkness. "Barked shins" and torn nylons will probably be the least of your rewards. Consider then the uncertainty and the fear which may be the patient's initial reaction to an entirely new situation. How long did it take *you* to understand the operation of a loom? It should be easy to be patient with a patient who, in addition to being sick, is confronted with the task of working on a loom; you *wanted* to learn to use it; does *he*?

Second, do we understand the patient's motivation? Here we look to some of the other "catalysts" on the therapeutic team for considerable help. The physician can give us his estimate of the patient's desire to get well; the social worker can provide us with valuable background data concerning the patient's family and work situation; the clinical psychologist can give us an insight into the basic personality pattern of the patient and may be able to give some helpful suggestions as to the best way in which to approach the patient to reinforce positive motivation or to de-emphasize negative attitudes. Other therapists such as physical and speech therapists may be able to contribute their observations. Last, but not least, the patient's family and friends may assist us greatly in our efforts to understand what makes the patient "tick". We may or may not be able to learn directly from the patient himself. He may verbalize very convincingly, but his performance may belie his words. Of course the reverse may be true. The importance of understanding the patient's motivation cannot be over-emphasized because our therapeutic effectiveness bears a direct relationship to this area of understanding. We may be successful in getting the hemiplegic patient, for example, to use his paralyzed arm, only to see him let it "freeze" into uselessness after he has left the hospital; he wanted or needed the apparent disability and worked with us only because he felt *compelled* to do so. In such an instance our catalytic activity has been in vain— we thought we were going to produce "high octane gasoline"; instead we end up with "sewing machine oil."

Third, do we recognize and respect the patient's goals? We may appreciate his point of view and have a good understanding of his motivation, but if we do not recognize and respect his goals (immediate, intermediate, and ultimate) we are cracking the raw material without benefit of controls. Why is an understanding of goals important? Petroleum engineers set out to achieve certain end products starting with the crude oil. Can you imagine the waste and confusion which would result if the several end products were left entirely to chance? A similarity exists in the therapeutic field but, in this instance, is somewhat different as we are attempting to appreciate the patient's goals rather than to "graft on" our own ideas as to what the patient ought to accomplish. We should not jump to the conclusion that we are not going to let the patient direct his own treatment; rather we should realize that our therapeutic efforts will meet with greater enthusiasm if we can let the patient demonstrate to himself that we are helping him reach the goals he has set. It is futile to explore vocational capacities when the patient is unable to take care of his daily needs. Let us, therefore, give priority to the area of self care and assist the patient to achieve this as an immediate goal. In this way our therapeutic efforts present a challenge to the patient. Once self care is accomplished we can proceed in an orderly fashion to assist the patient in reaching more advanced objectives. A frequent mistake is to expect too much of the patient. Generally speaking his goal is likely to be more modest than we would assume. With no implication of disrespect, it is well to keep in mind the old adage about being unable to "make a silk purse from a sow's ear." The ultimate happiness of the patient is best gained by helping him to reach or regain a living situation which gives him the greatest satisfaction. Any given situation might *not* satisfy us, but *we are not a part of the end product.*

The common denominator which runs through the entire consideration of "refining our resources" is the matter of intelligent inter-personal relationships. Our major resources do not lie in the area of specific skills or techniques having to do with arts or crafts. The most important contribution of occupational therapy is the occupational therapist. The therapist's greatest resource is his directed and dedicated service to the patient. We have attempted to analyze a few of the more important steps involved from the standpoint of the therapist and from the standpoint of the patient. It is apparent that the therapist's role in some respects is similar to that of the chemical catalyst—such an analogy is good as far as it goes,

(Continued on page 65)

DRESSING TECHNIQUES FOR THE CEREBRAL PALSIED CHILD

Part II, Fastenings

FOREWORD: To exchange ideas and discuss their therapy problems in relation to the cerebral palsied, the occupational therapists in and around New York City have been meeting bi-monthly. This paper is the result of their combined thinking and is Part II of an article on dressing techniques. Part I was carried in the January-February, 1954, issue of AJOT. An article carried in the September-October, 1953, issue pertained to their discussions of feeding training. A second article carried in the November-December, 1953, issue was concerned with teaching writing. The occupational therapists contributing the following article represent the following clinics:

Beth Israel Hospital, New York, New York
Cerebral Palsy League of New Jersey (Essex County), Newark, New Jersey
Cerebral Palsy Treatment Center, Hoboken, New Jersey
Godmothers League C. P. Treatment Center, New York, New York
Hospital for Special Surgery, New York, New York
Institute for Physical Medicine & Rehabilitation, New York, New York
Long Island College Hospital, Brooklyn, New York
New York State Rehabilitation Hospital, West Haverstraw, New York
Roosevelt C. P. Center, Roosevelt, New York
St. Vincent's Hospital — C.P. Unit, New York New York
United Cerebral Palsy, Middlesex County, Perth Amboy, New Jersey

INTRODUCTION

A large part of the occupational therapy program for the cerebral palsied is devoted to closings or fastenings: laces, tie-bows, buttons, buckles, zippers and grippers. They are therefore taken up here in some detail and broken down into steps for easier teaching. Emphasis is placed throughout on teaching self-application of fastenings first, if possible, instead of learning the techniques on Montessori boards. Also the techniques under each heading are graded from independent performance to assistance and then to adapted equipment. Learning on self is felt to be more meaningful and to promote more rapid learning than teaching on boards. The exceptions are: motor involvement limiting the child from reaching the necessary part of the body; difficulty in seeing to do the fastening, particularly shirt buttons; low mentality; poor comprehension; slow learning processes. In the evaluation of the child, the therapist ascertains at which level to start him. The child should be taught under as normal circumstances as possible, with teaching aids brought in only as needed.

The age levels given are the norms, established by Arnold Gesell, M. D., at which children master the techniques discussed. It is important not to expect the cerebral palsied child to perform activities a non-handicapped child his age has not mastered. Also the progression of learning should be kept in mind.

LACES

The child will have less difficulty if his shoes have double eyelets, that is eyelets on both the top and inside of the shoe. If the shoe does not come with them, the local shoe repair man can insert them. The laces should have metal tips which can be lengthened by putting two tips on the lace. (Supply houses are listed at the end of the article.) The laces should be of such size as to slide easily within the eyelet and slightly longer than usual.

UNLACING
(3 Years)

1. *Self Method*: Use the child's shoe or brace cuff. The fingers reach and pull the top lace working toward the toes. If the child has poor arm flexion and extension, he may hold his arm extended, flex his knee, grasp the lace and extend the knee to pull the lace from the hole.

2. *Table Method*: Use a lacing board or a regular shoe attached to a board. Place the shoe on the table with the toe away from the child to coincide with lacing as on self. Longer laces and two differently colored laces may help. Use the same procedure as unlacing on self.

LACING
4 Years

1. *Self Method*: The child must be able to reach his shoes and put his foot flat or be able to reach his shoe sitting with his knees extended. He must have fairly good flexibility and sitting balance. Also he must have the ability to hold the lace with enough skill to get it through the hole.

To facilitate learning, the child should be taught to leave the laces in the bottom holes. In lacing, he should always start with both laces on the same side of the shoe, cross the bottom one over first and then the top one.

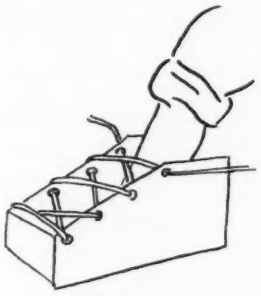
If the child has difficulty in learning the alternation, two differently colored laces can be tied together at the toe of the shoe so that the child learns to take first the yellow one and then the white one. This can be further reinforced if need be by painting the eyelets to match the lace which is to pass through it.

a. *Two-handed Method*: Hold the lace at metal tip with one hand while the other hand spreads the opening. Place the tip in the hole from the underneath part of the leather. Pull the tip up with either hand. Reverse and cross the shoe to lace the next hole.

b. *One-handed Method*: Technique varies with the motor involvement of the good arm and hand.

(1) If the motor action of the good hand is rated "good," the child can be taught to lace from the underside as in the two-handed method, although it will be slower.

(2) If the motor action of the good hand is rated only "fair," the child should be trained to lace from the same direction each time. Example: If right-handed, go from right to left with lace through all holes—under hole on left, over hole on right.



Wooden Shoe

1. *Adapted Equipment*: Used if the child cannot reach his shoes, or has poor hands. However it is useless to teach lacing if the child is never going to reach his shoes.

a. *Wooden Shoe on Self*: The child's foot and own shoe fit inside the wooden shoe which is placed on the floor. This has large holes, heavy cord laces and long tips.

b *Leather Shoe on Board*: A regular shoe is nailed to a board. A low shoe is best as the child can see all the holes. It is advisable to stuff the shoe with paper to give it body. Place the shoe in front of the child with the toe pointing away from him. If the shoe is placed at an angle, the child can see the holes better. The same methods apply as are used when the child laces the shoe on himself.

c. *Lacing Board*: A board with two leather pieces attached which contain eyelets. The lacing pattern is painted on the board in two colors. Two colored laces are used.

TYING BOWS

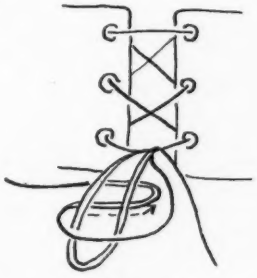
6 Years

A child may be 6-7 years of age before he can tie a firm and even bow.

1. *Self Method*: There are various two-handed methods. Selection of the method to be taught will depend not only on the child but also on the method the therapist knows best. It has been found that the method used to tie a bow varies slightly among many adults. The therapist should analyze his own method and then observe several adults so that teaching methods may be modified if necessary.

a. *Two-handed Methods*:

(1) Conventional: Make a single loop first. Draw the long lace around the loop and under and through the hole thus formed to make the second loop.

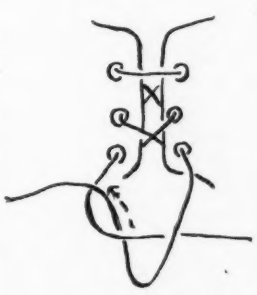


Conventional Bow

(2) Bunny Ears: Draw loops from the middle of each lace leaving sizable tails. Tie the loops like initial knot.

b. *One-handed Methods*:

(1) Figure Four: Cross the outside lace to the inside and hold it with the other foot. Cross the other lace over and around the lace held by the foot and pull tight. This makes the initial knot. To hold the knot tighter wrap the lace around a second time.



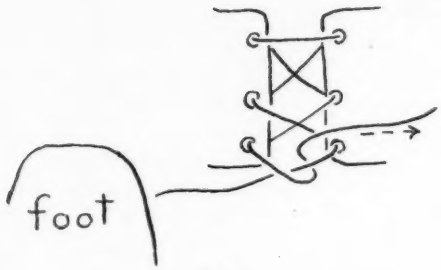
First Step in Tying Bunny Ears

Bunny Ear Bow

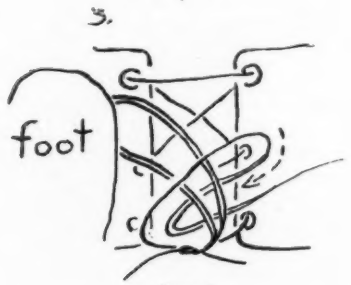
The opposite foot holds the inside lace. Lay the free lace on the shoe like a figure 4. The long lace, which was being held by the foot, goes over the figure 4 at the cross and under and through the hole. Tighten the two loops with the forefinger and thumb.

(2) Single loop or one-handed half bow: The initial knot is made the same as above. Hold the inside lace with the other foot. The outside lace crosses over the inside lace leaving a hole. The middle of the outside lace comes up through the

End Under Knot



Step 1



Step 3

hole and is pulled into a loop. The long lace is tucked in the shoe.

(3) End Under Knot: The initial knot is the same as above. The foot holds the inside lace. Loop the outside lace and stick the tip under the initial knot. This knot can be tightened by pulling the loop with the good hand while the other lace is held with the foot. Now pass the long end across the loop and pull through into a second loop. The foot can hold the first loop while the second loop is being tightened.

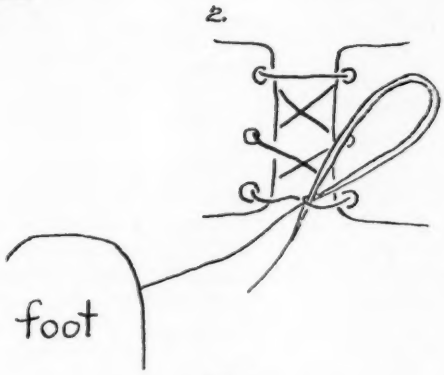
2. *Adapted Equipment for Tying Bows*

a. *Boards.* It may be helpful to have a board with laces of different lengths and widths. It may also help to have the left and right hand laces of different colors, with matching color diagrams for tying a knot and a bow on separate cards.

b. *Dressing belts* or separate sashes are very useful. A wide cloth belt that buttons around the child and has two long ties attached is good as it can also double for a button belt. Here the ties may be of two colors or one depending upon the needs of the child. The sashes also should be of varying lengths and widths to grade the child down to normal.

BUTTONS

In order to button clothes a child needs to have adequate finger dexterity so he can make his fingers perform different motions. Usually he needs to see what he is doing, although he can do buttons without looking if his sense of touch is good. It must be remembered in all buttoning that boys' clothes button left over right and girls' clothes



Step 2

right over left, so the child should be taught the appropriate method for his sex.

UNBUTTONING

(3 years for large buttons 1 inch in diameter to medium size 3/4 inch in diameter)

Self Method

a. *Two-handed Method*:

Girls: Left hand holds cloth next to buttonhole and pulls it down; right thumb and index finger grasp the button, turn it at a right angle and push it down through the hole.

Boys: Reverse hands.

b. *One-handed Method*: When the buttonhole is on the *same* side as the hand to be used, place the index and middle fingers under the cloth, one on each side of the button. Place the thumb on the button and push it down and through the hole.

When the buttonhole is on the side *opposite* the hand to be used, place the thumb under the cloth, touching the button. Place the index and middle fingers on top of the button, tip button and push through the hole.

BUTTONING

(4 years for large buttons)
(5 years for medium)
(6 years for small buttons 1/2 inch in diameter or less)

1. *Self Method*

a. *Two-handed Method*: In the initial stages of teaching this skill it may be helpful if the therapist holds the button while the child performs the rest of the operation.

Girls: The left thumb and one finger grasp the button and turn it on end in the same direction as the slit of the hole. The right hand holds cloth at the buttonhole and brings the hole over the button. The right hand and one finger then grasp the part of the button sticking through the hole. The left hand holds the cloth while the right finishes pulling the button through the hole.

Boys: Reverse the hands.

b. *One-handed Method*: If the buttonhole is on the *same* side as the hand to be used, place the

thumb through the hole. Use the thumb and index finger and/or middle finger to find the button and stand it on end. The index finger then guides the button and the thumb spreads the hole around it.

Reverse the method when the buttonhole is on the side *opposite* the hand to be used.

2. *Adapted Equipment*

a. *Dressing shirts.* To be used for treatment purposes when patients do not have appropriate clothing. Should be of various sizes with raglan sleeves for boys and girls. They should have large, medium and small sized buttons sewed so they stand up slightly from the cloth. Concave shaped buttons are usually easier to manipulate than convex ones.

b. *Button belt* or weskit to be worn by child for practice. Eyelets down the back aid therapist in adjusting the garment to fit the child.

c. *Button Boards* with cloth of contrasting colors on each side. All sizes of buttons should be available.

d. *Button box* or penny bank which may be used for early training in finger dexterity.

BUCKLES

UNBUTTONING
(4 years plus)

Self Method (Braces)

a. *Two-handed Method*: The left hand pulls the right buckle and vice versa. The right hand pulls the strap up and out of the center of the buckle and holds it while the left hand releases the prong. The left hand holds the prong down. The right hand pulls the strap the rest of the way out of the buckle.

b. *One-handed Method*: The same procedure with one exception. When jerking the strap to release the prong, flip the strap over the prong to push the prong flat on the buckle in order for the prong to stay down.

BUCKLING

Self Method

a. *Two-handed Method*: The left hand holds the buckle up with the prong out of the way. The right hand places the strap in the buckle and pulls the strap back beyond the hole the prong is to go into. The left hand puts the prong in the hole. The right hand pulls the strap over and the prong goes in the hole. The right hand then tucks the end of the strap in the other side of the buckle if possible.

b. *One-handed Method*: Before starting, push the prong out of the way. Place the strap in the buckle, then with the forefinger push the prong in the hole. Put the strap through the other side of the buckle if possible.

MISCELLANEOUS

Fastenings of this sort include large snaps, grippers, hook and eyes and zippers. A bead, tab or loop can be attached to a zipper for the child to grasp to close the zipper.

SPECIAL CLOTHING

In conclusion a suggestive list of special clothing for cerebral palsied children might be helpful to relate to parents and consequently to aid the therapist in teaching the daily skills of dressing.

The following are accumulated from therapists' actual experiences and observations.

1. Underwear. A size larger is preferred.
   a. Pants with elastic around the waist and pant legs
   b. Blouse and slip combinations
   c. Pajamas without fastenings. Jersey cotton excellent
   d. Brassieres with elastic shoulder straps and a fastening in front
   e. Half slips
2. Dresses. Should be a size larger or loosely fitted
   a. Dirndl skirt
   b. Dress with elastic waist
   c. Separate sashes so bow can be tied in front and turned to back
   d. Zipper closing on the side opposite the good hand
   e. Raglan sleeves
   f. Fastenings in front
   g. Washable material that is warm and light
   h. Select as fashionable styles as possible
3. Pants. Loose fitting
   a. Elasticized boxer style
   b. Avoid jeans with linings
   c. Flies should have zippers in place of snaps or grippers
4. Shirts. A size larger is preferred
   a. Polo or T-shirt
   b. Elastic cuff links
   c. Zipper fronts
   d. A hook sewed to the right front shirt tail and an eye sewed to the left front shirt tail can be fastened to hold the shirt secure around the hips and in the pants.
   e. An inch wide tape can be sewed around the shirt at the natural waist line. A 1/2 inch elastic threaded through the tape and secured at the front will also aid in keeping the shirt down.
5. Neckties
   a. Elastic neck bands
   b. Ties that clip on collar
   c. For one-handed tying, stabilize the end of the tie in a drawer and tie knot around end.
6. Skirts
   a. Dirndl tops
   b. Bands with inside rubberized for snug fit
7. Socks
   a. Avoid seams and elastic tops
   b. Sew a marker on the top of the sock to indicate the front and to prevent the child putting toes in the heel of the sock
8. Shoes
   a. Adapted closings
      (1) Elastic laces
      (2) Zipper closing
      (3) Buckle closing
   b. An aid for putting on shoes: place a strip of oilcloth in sole of shoe with a tab sticking out of the shoe at the heel. Place toes in the shoe on the oilcloth, pull the tab and slide the foot in the shoe while the oilcloth pulls out.

(*Continued on page 69*)

OCCUPATIONAL THERAPY IN PSYCHIATRY
Treatment or Tradition *

LAUREL V. NELSON, O.T.R.**

Since that first formal meeting of our Association on March 16, 1917, and through the 36 years which have followed, our leaders have succeeded in carrying us over many difficult obstacles. They have shown the way across many uncharted paths and through many trying situations, guiding the profession of occupational therapy to its present and respected permanent place in the broad realm of medicine.

In the process of professional maturation, some aspects of occupational therapy were able to become more finely differentiated than others. In orthopedics, for example, occupational therapy achieved a high percentage of favorable results through the development of various specific treatment methods. The physician, in prescribing occupational therapy for a patient with limited range of motion of a lower extremity, could usually expect improvement in his patient. The occupational therapist, by giving a series of treatments on the weaving loom, bicycle saw, and printing press, and with proper positioning, could demonstrate this improvement by daily recording the changes measured in the joint angle. The results could then be balanced against a constant, the normal range of motion. The evident, the tangible, the specific, were clearly seen when the benefits were evaluated.

This specificity was not possible in psychiatry. Fractured personalities and disturbed emotions were not susceptible to such precise prescription or to the application of already formulated occupational therapy techniques. In addition, the whole field of psychiatry was in a state of flux. Many new approaches, new trends, and new methods of treatment were introduced in the past three decades. Furthermore there was an extreme shortage of psychiatrists and their medical adjuncts to assist in the care of the patient. Although nearly one-half of the hospital beds in the nation were occupied by mentally ill patients, psychiatry was looked upon by many as a field composed of a multitude of sins—both literally and figuratively.

Despite these massive problems, a large number of occupational therapists were attracted to practice in psychiatric institutions. These pioneers numbered among the first group which founded our organization. Theirs was a calling which could not only render inestimable service to mankind but also could and did open a vast and challenging virgin field. They formulated and brought into existence many previously unknown techniques.

Many of you here know far better than I the conditions under which early psychiatric occupational therapists had to work, the problems they faced, and the advances which were made despite severe obstacles.

With innovations in the practice of psychiatry, many changes have been effected in all of the disciplines which serve it. Occupational therapy is no exception. In fact it is quite possible, despite many advances, that our discipline has not maintained the pace expected.

"Why not?" you may ask.

To answer your question, let us examine these changes.

A leading psychiatrist[1] in a recent speech stated that, "Psychotherapy, as we call it today, has gone through three stages—mystical, taxonomic, and now dynamic."

In the first stage we had no formal existence.

During the second stage our profession arrived. This was the era in which mental illnesses were classified by name as to major and minor designations. It was during this period that the occupational therapy prescription was drafted as a tool to be used in an attempt to outline a treatment program. The third stage—dynamic psychiatry—brought into wide use theories of motivation which offered keys to unlock the hitherto barred doors to the understanding of the mentally ill.

Few departments of occupational therapy have modified or changed the prescription form to meet the trend from the taxonomic to the dynamic in psychiatry. Many still operate with the use of the unwritten referral. It is quite possible that the demands placed upon many occupational therapy departments have prevented any degree of flexibility, either because they carry too large a load of patient treatment or because they are handicapped by administrative bottle necks, but this I believe is only a partial excuse.

The prescription is the whole basis for our authorization to engage a patient or a group of patients in an activity program. Why then, should we be self limiting in this, the keystone of our functioning? The physician needs a prescription form which permits him to prescribe effectively. We, in turn, take it in hand and follow its directives. It is not only within our province to assist

*Read at the 36th annual conference of the American Occupational Therapy Association, Houston, Texas, November 9, 1953.

**Coordinator, Adjunctive Therapies, Topeka State Hospital, Topeka, Kansas.

the physician in developing a functional outline that will enhance the treatment program, but it is also our obligation. We alone can apprise the physician of what we must know in order to be effective and what are the limits of our effectiveness.

The prescription form, which may have on it one of a number of terms such as "diagnostic classification," "working diagnosis," "mental diagnosis," or just plain "diagnosis," most usually is wasted effort. We all know that when given any two paranoid schizophrenic patients to work with, they may demonstrate completely different patterns of behavior. It would seem much more advantageous to use instead the term "outstanding symptoms." This will afford the physician the opportunity of describing a more accurate picture of the patient. The behavioral pattern that is characteristic of the patient is of infinitely more importance to the occupational therapist than the designation of a disease entity.

Similarly, the form which lists in column outline such phrases as "alleviation of anxiety," "outlet for hostility," "building self-esteem," and other such expressions, does not afford the physician a means for indicating what he may actually want his patients to gain from the activity. Simply stating, "what do you want the patient to gain through the activity," and allowing enough room for him to express his desires will be much more meaningful to the occupational therapist.

Other items on the prescription may be more functional. The mention of psychological precautions to be taken can save many undue worries and trying situations. Elopements, assaultiveness, and suicide are all limitations that can be understood, but if we know under what conditions these may be attempted, we will be in a much better position to help the patient.

Often an occupational therapist may lose any rapport that may have been established with a female patient the first time the patient is called Miss instead of Mrs., or vice versa. Information about the patient's feelings about specific matters may be very easily included on the prescription.

The disposition of completed prescriptions is another matter which should have some attention. Far too often we hear that the final resting place of this vital communication is in the office file of the chief occupational therapist. Here it gathers dust and performs no other service, except perhaps, when it is noted shortly after its arrival. Good medical practice demands that it be filed in the patient's master medical records folder. Here the physician has constantly before him a reminder to be alert to the need for continuous attention to further treatment plans. Considerations for tomorrow are as important as the plans for today.

The matter of progress notes is another item that may very well come before us for review. No standard form is needed here, only an acute eye, a sharp pencil, and the ability to describe what one sees.

This duty, which is also ours, follows just as night follows day. We receive our orders, the prescription, from the physician. To uphold our part of the program, we are required to report to him the manner in which the prescription was carried out and the results it obtained.

What should be the content of a report written about the patient? Here there may be diverse opinions or approaches.

Frequently occupational therapy is drawn into a blind alley. The individual patient is classified—there's that word again—by what he is doing and not what the activity is doing for him. The progress report, so often laden with repetitious phrases like "Mr. John Doe continues to weave on the loom in the afternoon," or "Mrs. Jane Jones finished knitting a sweater last week," can hold no claim for facilitating treatment. The occupational therapy department may be asked to run on a production line basis but the reaction need not be to describe the fabricated article.

We all know the patient may demonstrate a completely different pattern of behavior in an activity setting than he might while on his ward, at the barber shop, or even during the visit of relatives. It is important for the physician to know of the patient's behavior in the occupational therapy shop. If the so-called progress note could contain behavioral observations, these would be of far greater value to the physician who is treating the patient than sterile statements.

In the occupational therapy clinic, which almost always has a more normal atmosphere than the ward, the patient is afforded an opportunity to express himself within the limits of his illness. In these surroundings the occupational therapist can observe carefully the behavioral manifestations that may be displayed. Interpersonal relationships are easily noted in this setting. What is the patient's attitude toward the therapist; to the group; to the activity? What are the patient's relationships to others in the clinic? If we will keep uppermost in our planning that our program must be patient-centered instead of activity-centered, we will be in a far more favorable position to transmit to the physician concrete information about his patient's current behavior.

On the departmental level, many institutions persist in listing, by departmental breakdown, the materialistic gains derived from the various programs. The articles which are made by patients usually make up the full report of the department's operation. Sometimes the articles for sale

are listed. Supplies are priced and an itemized list of supplies and materials which go into projects is often enumerated. Little is said about patients.

I do not mean to imply that psychiatric occupational therapy has been a failure. Rather I seek to point up some of the areas of function that we may tend to overlook or toward which we may be devoting little effort. Many of you, I am sure, will agree that we know enough about psychiatry to realize that we know very little. Yet we must maintain a pace in keeping with psychiatric knowledge. We must make continued strides in this field, for fifty percent of all practicing occupational therapists are engaged in psychiatric occupational therapy and the demands for more continue to increase.

Rehabilitation programs came into being during and right after World War I. Through the 1920's and 1930's many excellent rehabilitation centers were developed. A number of occupational therapists helped to encourage these programs and not a few were an integral part of the staffs. Then came World War II. The role which the medical adjuncts could play had been fully proved by this time. The one thing that now stood out, however, was the acute shortage of professionally trained personnel. To overcome this shortage, and at the same time to be able to provide treatment programs for the many patients entering hospitals, a number of people were employed in occupational therapy who had limited knowledge of the skills they were to use, even though they possessed much the same amount of education and experience as those formally trained occupational therapists. The outstanding role played by rehabilitation people during the war and post war years is history. The fine programs they developed still exist.

Since this war-time situation, institutions throughout the country became aware of the role which a good rehabilitation program could play and many of them enlarged the scope of their rehabilitation programs. Many of the people who had become interested in rehabilitation during the war years moved into the civilian programs. New terms were adopted to designate their areas. Such titles as "rehabilitation therapies," "auxiliary workers," "various specialities," "related fields," instructional therapy," "paramedical specialities," "functional disciplines," "ancillary workers," and "physical medicine rehabilitation therapies" were used.

Often it was the neuropsychiatric hospital which enlarged its activity treatment program. But here there was, and still is, a shortage of physicians to properly guide these treatment programs.

A number of departments of occupational therapy fell into this sea of semantics. In addition, few had adequate medical supervision of their many functions. The few physicians available seldom knew which way to turn when it came to prescribing an activity for their patients. Apparently, with so many activities available for his check list authorization, and with no one to whom he could turn directly for guidance, the physician probably not too infrequently prescribed nothing.

The time, effort and money that some institutions spend in driving the physician away from his clinical areas is beyond all belief. Elaborate and costly shops are set up far from the ward building in which the physician usually has his office. To these central shops go his patients for treatment sessions. The physician, with his busy schedule, is seldom able to visit his patients in these settings or to confer with the occupational therapy staff working there. It is not too uncommon to find these shops located a quarter mile distant from the ward building. Other central shops are set up where the unescorted patient may go. All too frequently the patients who gain any benefit from this type of program are those patients who are willing to ask for such assignments.

To be maximally effective, the occupational therapist and occupational therapy facilities should be geographically and psychologically close to the ward and the physician. This is the manner in which we should operate, "rubbing elbows" with the patient and physician. Here the occupational therapist may attend frequent psychiatric teams meetings conducted by the physician, where he, along with the psychiatric aide, nurse, and other team members, may keep abreast of day to day changes in the treatment program. Here the occupational therapist is constantly in touch with the patient even when the patient is not in the shop. Here he can be familiar with what is taking place on the ward and with the other team members. Only in this way can the occupational therapist be truly a part of the psychiatric team.

The physician, when he first enters psychiatry, is faced with a far different task than the one who engages in general medicine and surgery. Throughout his training for this service to mankind, he has been repeatedly told, and supports the doctrine, that he and he alone is responsible for his patients. The physician engages the patient, gathers the facts, makes a diagnosis, prescribes treatment and takes the complete responsibility for the end result.

When the new physician enters on duty in an institution which treats the mentally ill, he is confronted immediately with fifty to five hundred, or even more, patients who are placed in his care. He must find it difficult to authorize others to "treat his patients." He must find it almost impossible to know how each is doing from day to day. In the larger psychiatric hospitals, the physician is fortunate if he himself can give fifteen per cent of the treatment his patients receive.

(*Continued on page 65*)

NATIONALLY SPEAKING

PUBLIC RELATIONS AT THE GRASS ROOTS LEVEL

No longer is "man bites dog" news.

But when the president of a company bites a chicken leg in the interest of the local community chest that is NEWS.

The basic principle still underlying public relations is news. This is as true of radio and the relatively new medium, television, as it ever was of the magazines, newspapers or other newsprints.

The public relations counsellor, representing a client, must offer to the channels of communication something that has never been seen or heard before, something that is calculated to interest the medium's reader, listener or viewer.

This implies that the *"something"* is a fact or collection of facts which is only accessible to the public relations man. Otherwise the channels of communication would not need deal with him; their own reportorial staffs would be adequate.

But this is not so. It would take a staff ten times its present size for the *New York Times* to fill the pages it prints every day. Without the aid of public relations departments and counsellors (agencies), the *New York Times* would not be able adequately to cover the really vital stories which develop every day concerning politics, charity, welfare, art, literature, medicine, science and industry.

The space—the air time—is there for these interests to command. Alert interests do command it.

But the years have made a vast difference in the quality of news that the modern public relations counsellor offers the media of communication compared with the "stunts" that the old-fashioned press agent staged. The philosophy of any interest in its relationship to the public is a million miles from old Commodore Vanderbilt's, "The public be damned!" The key to modern public relations is, "The public be served."

There is also a vast difference between the old-fashioned publicity technique of sending 5,000 mimeographed "releases" across the country to 5,000 bored and inundated newspaper editors and the modern technique of forward-passing the story from national headquarters to a public relations deputy located in the individual community.

All this is by way of saying that the public relations counsellor is an enlightened and useful professional in our modern society. That means *you*, if you are in any way charged with protecting or enhancing the good name of an organization: industrial, professional or civic.

To describe all the activities and responsibilities of the public relations function would fill a book (indeed, many years ago I filled one), but the purpose of this paper is limited to describing how these operations at the local level may fit in and cooperate effectively with a campaign on a national scale. In fact, they may spell the difference between the success and failure of the campaign.

CAMPAIGN METHODS

There are two ways in which a national public relations campaign may be undertaken. I shall mention one of them merely to dismiss it. Sometimes a public relations agency, or the public relations department of a big company, will attempt to reach all communications outlets in all parts of the country from its own central office. This means that the local newspaper is covered either by mats and mimeographed copy or through syndicates. The local radio and/or TV station is similarly supplied with script material or with tape-recordings from the central agency or a network is relied on to do the job.

An operation of the above nature is sometimes necessary where the organization involved lacks local contacts through sales offices or subsidiary groups. It is never, however, as effective as a campaign in cooperation with public relations representatives on the community level. These deputies have the tremendous advantage of knowing local attitudes, prejudices and particularly local personalities. The last is frequently the most important consideration and exactly the point at which an otherwise well-conceived national publicity campaign may break down. Multiply this breakdown by a couple of hundred special personalities in a couple of hundred other communities and you have effectively spoiled the best-projected "story."

Let's cease dealing with generalities, always a mistake in such an over-generalized area as public relations, and get down to cases. Let me cite a public relations operation which worked so smoothly and effectively from the central office of information down the line to its final grass roots impact that it has become to my mind a kind of classic of its kind.

The case was a problem which confronted the Wisconsin Canners Association several years ago. There was a conflict between the canners of the state and the growers of canning crops over the question of responsibility for the condition of the soil. At first each side accused the other of "mining" the soil, that is, not providing for "rest" years when the land should be sown not to market crops but to less profitable feed grass. As a consequence of this divided responsibility, no one assumed any responsibility and in many parts of Wisconsin a

serious condition of soil depletion became apparent.

The Wisconsin Canners Association finally took the bull by the horns and decided they would do something about it. The "something" took shape as a full-fledged statewide campaign to educate all of the people, consumers and canners and farmers alike, to the need, the facts and the practices of soil conservation.

Here was a public relations activity in the very best sense, in the service of all the people. And it was a campaign which finally paid off because of the use of public relations techniques at the community level. The fact that the campaign was statewide rather than national was of no importance; the principle of cooperative effort on several levels was the same.

First the public relations counsellor mustered the help of the College of Agriculture of the University of Wisconsin and the state conservation office of the United States Department of Agriculture. Together these forces worked up a booklet, "Sun, Soil and Survival," which squarely faced up to the issue.

"It is not yet quite a famine," copy explained, "we have merely inherited a depleted dish, and a warning. In many parts of the state, the soil has been overworked, proper conservation methods have not been applied and many of the precious elements have been depleted. The famine is in sight only if we don't heed the warning."

With effective before and after pictures and primer-clear copy, the booklet described the basics of soil conservation as well as its significance in preserving the nation's health and economy. A prominently placed paragraph told farmers that the Wisconsin Canners Association had been assured that "any farmer or canner who sincerely desires to restore and maintain the fertility of his soil will be given the benefit of the technical knowledge" of government and university conservationists.

The association's canners bought thousands of the booklet, imprinted them with their individual slugs and distributed them to their growers. County agents and university representatives personally visited many farmers and plugged the conservation program. Everyone hopped on the bandwagon.

With the canners' own farmers alerted, the next step was to bring the "save the land" message to growers and consumers generally throughout the state. To do this the booklet was broken down into ten articles which then were offered to Wisconsin newspapers. And this was where the effective "grass roots" activity came in. The offering to the newspapers was first made from the canners association's headquarters in Madison, the capital of the state. But the acceptance was only fair until headquarters appointed a local public relations representative in each farming community of the state with instructions for him to call upon the local editor and persuade him of the value of the material.

In approximately 10 cases out of 10, the local editor turned out to be a friend of the local public relations representative (usually a cannery executive) with similarly enlightened views about the public good. It was not difficult for them to get together and agree that a soil conservation campaign had not only significance for the whole state of Wisconsin but for the growers of the particular community in which they lived.

As a result of this technique, the message of soil conservation in ten newspaper articles and in many radio broadcasts was carried to practically the entire agricultural area of the state. This penetration would not have been possible had it not been for the work of those public relations deputies at the grass roots.

TECHNIQUES FOR OT

Similar possibilities of telling a good news story are offered to the individuals charged with the public relations responsibilities of state and regional groups of the American Occupational Therapy Association. An experiment of a sort was tried by the Association last summer in the form of a mat story based upon the occupational therapy article which appeared in the August issue of Pageant Magazine. AOTA headquarters in New York advised state and regional groups of the Association that such a story was being prepared, and asked the public relations officer of each group to request the number he or she felt could be placed with newspapers in the area covered by the group. Though the time was short in which to make sure that publication of the mat story would coincide with the Pageant story, the results attained in terms of clippings in different newspapers were sufficiently good to demonstrate the soundness of the technique.

Ideally the local operation should start with interviews between the group public relations officer and the newspaper editors and radio/TV producers of his area. The public relations officer should tell in general the story of the profession, outline the local needs and indicate what the state or regional group is trying to do to meet them. He should then describe to the editor what materials are available from the regional or national office and in what form they are available, i.e., photographs and copy or mat.

As a result of this conference, the editor or producer will state his needs. He may want only a local story written by the local public relations representative. He may wish to assign a reporter to attend a clinic or visit a hospital or patient, in

which case the public relations officer will, of course, volunteer to escort the reporter and make the necessary arrangements so that the reporter's task is easy and interesting.

Finally the editor may wish to dig more deeply into the facts of this new and vital profession. And this may call for materials which only the national office is in a position to assemble in a comprehensive way. And you can be sure that the national office will do so comprehensively and promptly.

SUMMARY

Five suggestions for the public relations approach to hometown newspapers, magazines, radio and TV stations, clubs and churchs are:

1. Give a brief picture of what occupational therapy is. Remember that the profession is wholly new and unfamiliar to most people.
2. Tie in the local angle quickly. Remember that the editor or producer or club president is mainly interested in *his* town (your town).
3. Suggest the assignment of a reporter (or script writer) to do a feature story. But be sure you have a subject in mind—a hospital, clinic, technique, patient, etc. And remember that the editor is more interested in persons than things.
4. Offer to write a story (or script or paper) along the lines your interviewer suggests.
5. Make known what materials are available from regional or national offices.

Charles Bonner

Public Relations Consultant to AOTA

Editorial

INSTITUTE AN OPPORTUNITY

Occupational therapy departments are often relegated to obscure corners or inadequate quarters because hospital administrators don't always realize the full value of our program and often our departments are not used to their full advantage.

This is usually our own fault. Hospital administrators have failed to comprehend the full effectiveness of our program because we have not adequately presented our value or we have underestimated our true place on the hospital team.

In May, at the institute conducted for us by the American Hospital Association, we can learn how to best coordinate occupational therapy with other hospital services, how to organize our department for the best results within the hospital and how to effect successful public relations.

The American Hospital Association is truly offering us an important opportunity that will behoove all of us to accept. We are being offered the chance to study and learn the best ways we can serve a hospital. Such a study can aid in the fundamental growth of the profession and we should all thank the American Hospital Association for their interest and the service they are offering to us.

AMERICAN HOSPITAL ASSOCIATION *INSTITUTE FOR OCCUPATIONAL THERAPISTS*

May 6, 7, 8, 1954

The American Hospital Association has annually conducted an institute to help coordinate specific departments within the total hospital routine. The American Occupational Therapy Association is fortunate to be the group chosen for this year's institute which will empasize the need and more effective use of occupational therapy departments within hospitals.

May 6-8, 1954, has been chosen as the date for the institute which will be held in Chicago because of its central location. These dates coincide with the annual Tri-State (Wisconsin, Indiana, Illinois) Hospital convention which always meets in Chicago.

Emphasis will be on organization and the various sessions will be divided into the following sections:

Basic hospital organization. The purposes of the hospital and the manner in which it is organized to fulfill these purposes.

Department organization. The organization and administration of an occupational therapy department. Determination of function of the department. and description of the organization required to fulfill the purposes of the department.

Medical supervision. The place of occupational therapy in medical treatment and the medical responsibility for supervision of occupational therapy.

Interpreting departmental services. Necessity for clear understanding of the value of occupational therapy and the integration of occupational therapy with other therapeutic activities.

Need for adequate reports to the administrator and to the medical staff and the interpretation of occupational therapy to the patient, to the patient's family and to the medical social service department.

Patient's record. Evaluation of records, achievement charts, graphs and measurements, and statistical records of departmental operation. Also the importance of integrating occupational therapy records with general medical records.

Interdepartmental relationships. The importance of close cooperation between departments to obtain the best results in patient care. Understanding of the rights and duties and contributions of other departments, and orienting other departments to the value of occupational therapy.

Human Relations. Study of interpersonal relationships with patients and the hospital personnel.

Utilization of personnel. Determination of work volume, assignment of professional personnel and utilization of non-professional staff.

Utilization of volunteers. Evaluation of the volunteer in occupational therapy and the responsibility of hospital administration for establishing policies concerning volunteers. Relationship of the occupational therapy department to women's auxiliaries.

Problem clinic. Discussion of questions submitted by the audience.

Preparing the budget. Study of basic principles of establishing a budget covering income, expense, expendables, non-expendables and equipment; the application of these principles to the budget of the occupational therapy department; the relationship of departmental budget to hospital budget.

Schedule of charges. Establishing a schedule of charges based on the various types of institutions and the types of treatment programs.

Purchasing. Responsibilities to be assumed by occupational therapy departments in presenting specifications for purchases and the establishment of purchasing procedures within the hospital.

Analysis of functions. Analysis of the job of the occupational therapist with reference to the budgeting of time and energy, the proper division of duties between professional and administrative services and the supervision of personnel, management of department, training of department personnel, conferences and meetings, patient records, administration of budget, utilization of non-professionals and volunteers, reception of visitors and participation in general hospital activities.

Public relations. Evaluating public relations with women's auxiliaries, service clubs, schools, community centers, professional organizations and medical societies; with newspapers and public information agencies; with reception of visitors to the department; and lectures and demonstrations within the community.

The institute may be attended by anyone who is a member of the American Occupational Therapy Association or who is employed by an institution that is a member of the American Hospital Association. The tuition fee is $30.

The American Occupational Therapy Association is fortunate to have been chosen by the American Hospital Association as the recipient of such a valuable study which will be of inestimable advantage to both occupational therapy departments and hospitals.

For room accommodations write:

H. G. Finnsson, Reservation Manager,
Palmer House, Chicago, Illinois.

For further information about the institute or registration form, write:
Charles U. LaTourneau, M. D., Secretary,
Council on Professional Practice,
American Hospital Association,
18 East Division Street,
Chicago 10, Illinois.

Calendar of Events

May 6-8, 1954
American Hospital Association
Institute for Occupational Therapists
Chicago, Illinois

June 6-16,1954
Teachers College, Columbia University
Work Conference on Developing
Student Leadership
New York, New York

June 27-July 2, 1954
Annual Conference of the American
Physical Therapy Association
Statler Hotel
Los Angeles, California

June 28-30, 1954
University of Michigan
Workshop on Aging
Ann Arbor, Michigan

July 19-30, 1954
Teachers College, Columbia University
Work Conference on Improving
Staff Relations
New York, New York

August 2-13, 1954
Teachers College, Columbia University
Work Conference on Planning
Workshops and Conferences
New York, New York

August 16-21, 1954
First Congress of the World
Federation of Occupational Therapists
University of Edinburgh
Edinburgh, Scotland

September 6-10, 1954
Third International Poliomyelitis Conference
University of Rome, Orthopedic Clinic
Rome, Italy

September 13-17, 1954
World Conference of the International Society for
the Welfare of Cripples
The Hague, Netherlands

October 16-23, 1954
Annual conference of the American Occupational
Therapy Association
Shoreham Hotel
Washington, D. C.

FEATURED O.T. DEPARTMENTS

THE USE OF HOSPITAL RESOURCES AS TREATMENT

Veterans Administration Center
Waco, Texas

Louise McMillen, O.T.R.

The resources of large hospitals—their industries and necessary maintenance—have provided work for mentally ill patients throughout the years. This work, which had to be done by patients, often was the only activity available to them. However, good doctors and ingenious personnel have always been succesful, to some degree, in adapting this necessary work into therapeutic activities.

Seven years after the World War II, the problem of chronic psychotic patients in Veterans Administration hospitals is now comparable to that in state and county institutions. Waiting lists are growing longer and the majority of those now entering our hospitals have service-connected illnesses so they, too, have been sick for a number of years. It is evident that most of our efforts must now be directed toward rehabilitating the chronically ill.

They can be given custodial care without too much effort, but this seldom gets one out of the hospital and returns a functioning personality to society. Most of these patients are capable of more hours of activity than can be offered in OT clinics, and many are above the level of the craft work that can be provided. We, as occupational therapists, must offer something beyond this usual type of program.

Most psychiatric OT's find industrial therapy to be the best answer so far to this problem. However, it is evident that such a treatment program must have the needs of the patients as its first consideration, rather than those of the hospital. The supervision of an industrial therapy program in a VA hospital is the responsibility of the physician in charge of the physical medicine and rehabilitation service or his designate. At the Waco Hospital, this responsibility is delegated to our occupational therapy section. In no instance is our section accountable for the management or operation of the work involved, but it is our responsibility to supervise the treatment of patients who work in this program and to evaluate their adjustment and progress. Of the 2040 male patients in our hospital, approximately 600 have some industrial therapy assignment. Because of such large numbers it is only possible and practical that we work with them in groups.

It is always a problem to provide sufficient personnel to cover such a large program. Two of our occupational therapists, one full time and one part time, directly supervise the program, but we must depend on others to attend the patients in their work. This has been solved to some extent at our installation by the use of hospital psychiatric aids. Many of the non-privileged patients work in groups of from 25 to 30, and each group is attended by two of these aids. Other patients are assigned to various jobs throughout the buildings and are guided by aids on the wards. Privileged patients are usually assigned individually to various jobs throughout the hospital where they are directly supervised by various hospital employees.

Most of the industrial groups are assigned to various outside jobs. There are five groups who work on the grounds cleaning, sweeping the walks, picking up papers, mowing the grass and watering shrubs. Two groups of patients work the farm cultivating, harvesting, shucking corn, repairing fences and other farm jobs. Another group works in the laundry sorting and folding hospital clothing and linens and a group also helps with the more routine painting.

The occupational therapy sewing and upholstery clinic is a part of our industrial therapy program. This clinic has proved one of our best for long term chronic patients, and many of the men have become stabilized in their behavior while working here. The furniture repair shop has also proved to be excellent for large numbers of these patients. A wide range of activities is possible and this work offers excellent prevocational training.

Individual patients are assigned to special jobs at the farm. Others may be assigned as messengers, to help in the clothing rooms, as janitors in various buildings and offices, as projectionists and recreation and library assistants. Patients also help on the laundry and trash trucks. Those having privileged status may be assigned for work in the greenhouse and gardens. Others are assigned to the various kitchens for non-foodhandling jobs. A few patients are individually assigned to the engineering department. In the future we have plans for more men to be used as helpers for the hospital carpenters, painters, plumbers and electricians.

We are now making use of most of our hospital resources so that we have a great variety of activities. The individual needs of the patients should always determine their activities and a patient's assignment in this therapy is the responsibility of the doctor. The large number of patients assigned to each of our ward physicians and the constant

Condensed from a speech read at the 36th annual conference of the American Occupational Therapy Association, Houston, Texas, November 9, 1953.

ward transfer of patients present definite problems. It is most difficult in our installation for a psychiatrist to know each of his patients well enough to always prescribe the best activity possible for each individual.

For this reason everyone who knows these men must help see that each is receiving the best treatment possible. Most of our doctors are cooperative and appreciate information about their patients. The occupational therapist who supervises industrial therapy visits the wards daily and confers with the psychiatrists. She reports on patients who might benefit from a higher level of work, need a change of activity or have shown interest in other assignments. Comprehensive notes evaluating each patient's behavior, adjustment and progress are written as often as possible. These are filed in the patients' permanent records where they are available to doctors and professional personnel. Board meetings are held regularly on several wards. Here patients are presented and their total treatment is discussed by the personnel who work with them, and plans are made for further therapy.

To aid the psychiatrist, the therapists write job analyses containing information concerning the actual work involved, the precautions necessary, the environmental conditions, the supervision the patient will receive and other helpful data. Efforts are made to see that patients do not remain at one level of any assignment as the correct job for a patient at one time will not always continue to be so as the patient changes or improves.

This principle of therapy can be easily overlooked for the insurmountable numbers of patients make it such a temptation to leave an individual in a job if he seems to like it and becomes adjusted to it. This method does not lead to rehabilitation but encourages hospitalization because patients who continue in the same assignment month after month, year after year, become so secure in their work they have no desire for anything new, and this includes leaving the hospital. I know of patients who have returned unnecessarily early from their visits home because they felt they should get back to their assigned jobs. Others have become very disturbed (and problem patients) when moved from an assignment to which they had become too accustomed.

Of course, we find some of what has been called the "sabotage from within," such as must be confronted in all such institutions. This happens at times when a patient fills a certain need of his supervising employee. Personnel, often unconsciously or with good intent, refrain from suggesting a patient for advancement although he has shown marked improvement but has reached the maximum level in his present job. The employee has overdone a good job of relating with the patient until a mutual dependency has been established.

These situations are hard to break down but they do not present the problems for us now that they have in the past. Our manager sets the policy throughout the hospital that the patient comes first. No time limit or pressure can be put on work orders filled in the various activity clinics.

If industrial activities are to provide real and healthy situations, the work must be balanced with planned recreation. This program, as all those in the physical medicine service, is coordinated with the recreation section and each group of patients has one afternoon a week for parties and sports. Monthly dances and weekly movies are also provided for these patients and each is taken on a weekly visit to the hospital canteen.

The engineering service provides a truck and driver each morning to deliver coffee or iced tea to patients on outdoor assignments. A therapist goes on these rounds and encourages talk and socialization among the groups. These coffee "breaks" provide a normal social situation and have proved very worthwhile.

The schedule of work is set up on a five-day week except for a few special weekend jobs. Most patients have more leisure than they enjoy over the long inactive weekends, but this will continue to be a problem in VA hospitals, as long as most personnel work on a Monday-through-Friday week.

For this treatment to be successful in any way, hospital employees must have some knowledge of mental illness and an earnest desire to help these patients. Also they must have an understanding of the treatment objectives and appreciate their responsibilities in this program.

The supervision and training of these employees pose several problems. Our occupational therapists are handicapped for none of the personnel who directly supervise the patients in this program (except an aid in the sewing clinic) are members of the occupational therapy staff. It is most difficult to direct someone's performance when he is rated and supervised by another service. However we are making some progress and during the past year have managed to have short but rather inclusive training courses for supervisors of the engineering service and for the hospital aids assigned to industrial therapy. The training for the engineering personnel included lectures by psychiatrists on the basic mental illnesses, their causes and treatment, as well as the aims and principles of activity therapy and the management of patients. This was only a beginning and more training and repeated courses will have to be given before we really have accomplished what we would like with these employees. Such personnel are just beginning to accept the concept that they have a part in the treatment program.

We feel that continued supervision and training

are required. To provide these the therapists must be adaptable and cooperative and by their own personalities gain the confidence and respect of the personnel. They must be able to coordinate (and sometimes compromise) their ideas with other services in the hospital. Above all the therapists must be efficient, interested and enthusiastic about this work and these patients so that they can motivate others to carry on this treatment effectively.

We are cognizant that we are just one group trying to help our patients and that no person or treatment alone can rehabilitate a single one of them. Throughout our OT section a therapist's success usually depends on her ability to relate with the ward physician and other members of the treatment team. However in no other part of our service is this interrelationship so necessary as in industrial therapy. To keep patients assigned to the activities which best suit their needs and at the same time to keep all work projects going requires the cooperation of the industrial therapy unit and almost every service in the hospital. Gradually this integration is being accomplished through our training courses, the guidance of our chief of physical medicine, the efforts of our therapists and by the results of our program.

The relationship between the occupational therapy section and social service is outstanding and unique in our hospital. In such a large installation where the few psychiatrists can give us little of their time, it is the social worker who can often help us the most. Much of the progress of our industrial therapy program during the past months has been due to the close collaboration of the supervisor of this program with the social workers assigned to the wards which furnish a majority of the industrial patients.

The therapist and the social workers meet regularly to screen these patients and discuss those who need change of assignment, who might progress to a higher level of activity, might be able to be given privileged status or might be feasible subjects for post-hospital planning. The names of patients and recommendations are presented to the ward physician and, from these and others he may wish to review, he decides on the patients to be presented for his ward planning board.

These board meetings have done a great deal to carry out the team approach with our chronic patients and through them the value of selected and graded activity is gaining recognition. Those attending these conferences include the ward physician, chief of physical medicine and rehabilitation, chief of continued treatment (chronic) service, chief of social service, vocational counsellor, chief occupational therapist, industrial occupational therapist, ward nurse and ward social worker. Others who may contact the patients are present when possible and indicated. The social worker who has previously interviewed each patient and prepared him for his conference gives a short resume of his social history and progress in the hospital. The therapist presents the adjustment of each patient in his assigned activity and may recommend change or advancement. Others give pertinent information, opinions or suggestions they may have. Each patient is brought in before the board to express his own goals and is encouraged by the physicians to ventilate any of his feelings or problems. This in itself is often very therapeutic for these chronic patients may feel rejected and forgotten.

Some decision or plan is made for each patient which ranges from continuing the same treatment for a few patients to changing the assignments for many. As a result some patients are moved to a privileged ward and at times immediate post-hospital plans are made for others. These boards have proved most valuable in the progess and rehabilitation of chronic patients, for without them the potentialities and needs of many of these men would have continued unnoticed or forgotten.

There is a close liaison between the physical medicine rehabilitation and vocational counseling services in our hospital which is most helpful. Our vocational counsellors believe that a patient's actual performance at a job provides a more valid evaluation of his ability than written and verbal aptitude tests. They follow up their own findings by suggesting further testing of patients in actual assignments similar to the work or training planned for post-hospitalization.

A transitional program for patients hospitalized for long periods of time is available at the Josey Vocational School which is part of the Sam Houston State Teachers College at Huntsville, Texas. Regular monthly visits are made to the school by a vocational counsellor and a social worker from the hospital and a VA training officer from the Houston regional office. They confer with the instructors as well as the patients to help both in any problems they may have encountered. Some of our chronic patients, including a number of those who have had leucotomies, have been at this school. The social environment is acceptable to these men and the instructors have an unusual understanding of handicapped people.

Within the past months our hospital has been sending some patients back to the community into homes that are not their own under the supervision of a social worker. So far these patients have been found to adjust best in farm communities, and industrial assignments on the farm can be a helpful transition before leaving the hospital. Numbers of other chronic patients, often those too old to adjust outside but who have shown

that they can get along well in the hospital community, are being sent to VA domiciliary homes.

It is the responsibility of those who treat our patients to watch for and to suggest those who might be feasible subjects for any of the above dispositions. The occupational therapists must continually keep this in mind as they consider the many patients assigned to their program.

More and more as we work with chronic psychotic patients we realize that they do have potentialities in spite of their seemingly irreversible symptoms. We have learned to ignore as much as possible their disorganized behavior and to work with those portions of their personalities which are still functioning at the reality level. We realize that it is not their delusions, hallucinations and eccentric behavior which usually incapacitates them, but rather their inability to adjust to the demands of the outside world. If we can help them in their relationship with others in the hospital community and aid them to advance to their highest level of functioning we have reached our goal.

OCCUPATIONAL THERAPY DEPARTMENT THE HARTFORD REHABILITATION CENTER, INC.

Hartford, Connecticut

J. Sokolov, O.T.R., *Executive Director*

The Hartford Rehabilitation Center, Inc., an affiliate of the Connecticut Society for Crippled Children and Adults, was initially conceived as the mutual brain-child of the Hartford Tuberculosis and Public Health Society and the Connecticut Society. In 1939 these agencies joined forces in an attempt to meet the needs of the newly discharged tuberculosis patients for work tolerance and training programs prior to engaging in full-time employment. With the advent of World War II, many of these clients were absorbed into part-time jobs and the caseload of the Community Workshop (as it was then known) began to reflect orthopedic and neurological disabilities.

This provided the Easter Seal Agency (Connecticut Society for Crippled Children and Adults) with a golden opportunity to "practice what it preaches," namely "to fill the unmet needs." Hence the affiliation with the Tuberculosis and Public Health Society was amicably dissolved and the wheels were set in motion to provide curative workshop services for the convalescent physical disability patient.

To recount the labored progress of the past seven years would be to presume upon editorial courtesy and doubtless to relinquish many friendships. The pangs and pleasures of growth are surely as familiar to all of us as our given names.

Suffice it to say, the Hartford Rehabilitation Center, Inc., has emerged out of this "slow sea-change." The Center is today an out-patient facility ministering to about 100-120 clients per week. These represent people with all the common and uncommon physical disabilities plus a group of "hidden handicapped" who are served by the sheltered workshop of the Center.

Patients are referred on individual prescription by more than 200 physicians in the greater Hartford area and 20 surrounding towns. All agencies concerned with rehabilitation problems, however varied, also refer clients through recognized medical authorities.

BASIC AIMS

The aims and purposes of the Center have been defined by continually studying the needs of its clients. In those happy instances where we meet the individual's need well, the natural corollary is satisfaction of our basic aims: to return the individual to home, school or job, maximally rehabilitated and socially responsible and productive.

The occupational therapy program obviously has major responsibilities in the fulfillment of these goals. It attempts to satisfy them by a four-pronged program inclusive of (a) kinetic occupational therapy, (b) functional training (self-care, physical demands of daily living, etc.), (c) pre-vocational analysis and training, (d) recreational and social pursuits.

We face life in the occupational therapy department without many of the time-worn frustrations. While no member of the department can be accused of complacency or myopic vision concerning room for constant improvement, we do admit to a spacious, well-lit and well-housed work area and an abundance of both standard and uncommon equipment. There is a reasonable annual budget for the department and the community has proven a rich and endless source of material and apparatus. These physical accommodations enhance the kinetic program and make possible, for the enterprising therapist, the creative use and skillful adaptation of media to achieve the objectives of increased motion and strength and improved co-ordination so often prescribed by the referring physician.

Functional training assumes a priority rating in many instances since a majority of our clients are faced with devising new approaches to the time-honored tasks that add up to personal independence. We are fortunate in the possession of a rather completely equipped, albeit modest, kitchen which enhances our work with the handicapped housewife. Regularly scheduled home-making classes are an integral part of this program and utilize the services of a trained volunteer who is supervised by one of the occupational therapists.

It is in the development of our pre-vocational program that we as occupational therapists are cur-

rently deriving extensive personal stimulation and satisfaction. All of us at the Center have recognized our normal frustrations when faced with patients who obviously need treatment and training which does not conform to either of the above mentioned categories. Each of us has wracked our respective brains in search of an answer to the overwhelming needs of the adolescent patient with cerebral palsy, the elderly hemiplegic, the unskilled epileptic, the physically handicapped patient additionally taxed with some mental retardation. As representative occupational therapists we have been tormented by the inadequacies of our tools when it comes to answering these problems. We believe we have begun to extricate an answer in a practical testing and training program which comprises in its experimental stages:

(a) specific simple tests in computation, writing and comprehension

(b) thorough testing for physical demands of daily living and jobs

(c) specific manual dexterity tests

(d) actual job operations which duplicate industrial situations

(e) sheltered workshop training

In the implementation of this aspect of the program the occupational therapist works in close co-operation with the sheltered shop instructors and counselors of the local Bureau of Vocational Rehabilitation.

The fourth element of our occupational therapy program relates to social adjustment and in this connection we have attempted to create an atmosphere fraught with the same elements of chance and adventure that form our daily existence. For example: patients prepare their own lunches, share K.P and purchasing of supplies, assist one another as they see the need, attend local concerts, theatre, adult education classes and movies, and maintain their own bulletin for inter-communication. We have found through sad error that the less we occupational therapists participate in planning at this level, the greater the chance for individual assumption of responsibility. We try to consider ourselves as catalysts in this procedure rather than expediters.

The occupational therapy department is enriched in its purposes and goals by the privilege of training affiliates from schools of occupational therapy and assisting in the training of physical therapy internes. These young "professionals" unleash talents, perceptiveness and a spirit of inquiry on our departments for which we as practicing therapists are deeply grateful.

A growing volunteer program brings its reward in a continuous two-way flow of information about occupational therapy and rehabilitation in general.

DEPARTMENTAL COOPERATION

If there is one belief beyond all others which we hold in common, it is that the value of occupational therapy for any patient is as strong as the weakest link in the chain of rehabilitation. In this connection we strive (many times at the price of personal sacrifice in time and effort) for constant active participation in and co-operation with all other departments. Scheduled and informal interdepartmental conferences (physical therapy, speech therapy, sheltered workshops, social service) plus weekly two and one-half hour intradepartmental staff meetings provide a steady medium of exchange of patient information. Monthly medical specialty clinics are attended by the full staff; bulletins and current reading files are maintained and contributed to by all. Individual conference time with the executive director is uniformly scheduled for staff members and additional time is available upon short notice. Integration with community agencies has been the responsibility of the executive director but is reverting to its rightful province as a social service department is being inaugurated. The staff is familiarized with this process by members of community agencies who address staff meetings. A counselor of the Bureau of Vocational Rehabilitation is appointed to meet regularly with the entire staff for specific discussions of mutual clients.

PLANS FOR GROWTH

Records compiled monthly by all therapists go out regularly to referring agencies and physicians and are referred to by the attending medical staff at all clinics. This provides us with an exceptional opportunity to portray effective occupational therapy to hundreds of professional people and is perhaps an incontrovertible reason for laboring to make our reports factual, informative and pertinent.

Since the Center is rarely at repose for long, it is fitting that this summary should end with a view to the future. In the four years since we have inhabited our present building, the program has burgeoned steadily. With the advent of a sheltered workshop and a social service department it has become obvious that additional space is no longer a luxury but a necessity. The board of trustees of the Center is currently coming to grips with this problem and we are hopeful of having the required space within the next six months .

The occupational therapy department, an integral unit of the Hartford Rehabilitation Center, Inc., anticipates the years ahead with the undiminished enthusiasm that has always prevailed.

People You Should Know

MARY FRANCES HEERMANS, O.T.R.

A Biographical Sketch
by
CARLOTTA WELLES, O.T.R.

Every month you receive a long letter full of just the news you are waiting to hear. This welcome communication which we know as the Newsletter is written for you by Mary Frances Heermans.

Miss Heermans comes from Mattoon, Illinois. She attended Eastern State Teachers College; in 1937 she received an A.B. from the University of Illinois; in 1941 she earned an M.S. in Biology from the same university. She taught general science at Central High School in Saginaw, Michigan; Western College then lured her to Oxford, Ohio, where she taught biology. Perhaps Miss Heerman's competence in biology accounts for her proficiency as a fisherman. She even cleans all her own catch and squeals only when trying to clean those which are still alive. She also makes those handsome knit and tailored suits she wears.

During World War II Lieutenant Mary Frances Heermans, USNR, served as communications officer for the Second Naval District, San Francisco. Further time was spent in the Fourteenth Naval District, Hawaii. After the war she studied occupational therapy at the University of Southern California and, in 1950, accepted her first position at the Los Angeles County General Hospital where she soon became acting head of the department. A year later she became acting chief occupational therapist at the Portland Rehabilitation Center. From there she was persuaded to come to New York in 1952 as assistant to the executive director in the national office of the American Occupational Therapy Association. Recently Miss Heermans was appointed as the new educational secretary to replace Miss Matthews who resigned as of April 1.

These are the facts, yet behind them you see a quiet leader who is so efficient that she was rapidly promoted to positions of greater responsibility. Behind her she has always left orderliness and goodwill, while those who have worked with her in every situation feel that they have spent each day in a climate of organized yet friendly efficiency. This is Miss Heermans who compiles your Occupational Therapy Yearbook, maintains the placement service and writes the Newsletter. This is "Mary Fran" who works for you in your national office.

Conference News

Come by car
Come by train
Come by bus
Or come by plane
But plan now to come to the Washington conference

Washington, our nation's capital and your conference city for 1954, is a tourist's paradise. The program committee is endeavoring to plan a program and schedule which will enable you to see as much of Washington and the public buildings and monuments as possible.

Connections and schedules in and out of Washington are excellent from all sections of the country. If you are driving there are many historical and scenic spots you will want to include in your itinerary.

Mt. Vernon—Washington's home on the Potomac.

Baltimore—Birthplace of The Star Spangled Banner.

Williamsburg—Restoration of old colonial capital of Virginia; College of William and Mary.

Jamestown—First permanent English colony in America.

Yorktown—Decisive battle of the Revolutionary War.

Hampton Roads—All the ships in the world could be anchored here at one time.

Richmond—Capital of the confederacy; St. John's church, scene of Patrick Henry's famous speech.

Annapolis—U. S. Naval Academy.

Charlottesville—University of Virginia; Monticello, Jefferson's home; Ash Lawn, Monroe's home; Mitchie Tavern, Patrick Henry's birthplace.

Skyline Drive—Over the top of the Blue Ridge Mountains, loveliest just at conference time.

Plan on attending the conference as it is an opportunity for professional growth and reunion with old friends. You can see where history was and is being made and you can feed your soul on the breath-taking beauty of the Shenandoah Valley all decked out in its gay fall attire.

We are fortunate in having secured the Shoreham Hotel as conference headquarters. The facilities there are excellent. Make your plans now to attend the conference in Washington, D. C., from October 16 to October 23, 1954.

Treatment or Tradition . . .

(*Continued from page 54*)

This means that a department of occupational therapy must often take the initiative in helping the physician make effective use of what it has to offer. Far too many therapists know their occupational therapy but are reluctant to let others "in on it" or assume that others already understand their function. When the occupational therapist, playing the role of an active psychiatric team member, seeks advice and guidance from the physician, the treatment program will follow a much smoother pattern. The occupational therapist, who tells the doctor, "A scrubbing activity should be prescribed for this patient," will seldom gain a favorable response. Although many times the doctor will not know the appropriate activity, if asked "What should we give this depressed patient?" he will more than likely be able to direct the formulation of a working plan.

The physician has the right to know, and to have explained to him, the effectiveness and benefits that may be derived from occupational therapy. If he is encouraged to use it as he sees fit, his appreciation of and interest in occupational therapy will shortly parallel that of the occupational therapist.

A department of occupational therapy should be able to demonstrate as clearly as possible that it stands ready to extend the patient program past the "busy work" or "buoying up" stage of treatment. While not for a moment decrying the value of keeping patients busy, "busyness" of itself is hardly therapy. If "busyness" is all that is offered, there is no role for the physician, no role for the occupational therapist in conjunction with the physician and consequently no occupational *therapy.*

To provide a well balanced schedule of activities requires a rather high degree of flexibility within any department—in personnel, equipment and the available activities. The department that limits itself to a strictly arts and crafts program and affords no schedule for social interests, physical exercise, reinterest in the community and similar outlets neither gives the physician a very wide selection of activities to be prescribed for the many needs found in his patients, nor creates a therapeutic atmosphere.

Dr. Karl Menninger states,[2] "In our theory, work and play are, next to personal attachments, the most important anchors of mental health." The physician, by skillfully prescribing a specific activity to meet a given emotional need, should be able thereby to provide all three conditions at once—but only if the occupational therapist, who must set the anchors, is familiar with the high seas of human emotions, is sensitive to the fresh currents of psychiatric theory, is aware of the dangers of drifting into a complacent calm, and is alert to the ever threatening whirlpool of repetitious activities carried on for their own sake.

REFERENCES

1. Masserman, Jules H., M.D., Professor of Psychiatry, Northwestern University. In a speech at the regional research conference of the American Psychiatric Association, at the Menninger Clinic, October 24, 1953.

2. Menninger, Karl A., M.D., in a "Foreword" written for a physician's guide to the adjunctive therapies, "Expressive Outlets Through Directed Activities," Topeka State Hospital, June, 1953.

Our Resources . . .

(*Continued from page 47*)

but it cannot be carried too far. Service to humanity far transcends even the most complicated chemical reaction in complexity and potential variations. However, the basic considerations which have been enumerated should be helpful in providing guide lines for the never-ending refining process which we call treatment. It is in the challenge of infinite variation, new and stimulating problems, and oft-repeated triumphs shared with our patients and other catalysts on the therapeutic team, that we find our greatest professional satisfaction. To see one mind returned to balance, one hand no longer useless, one child in school in a regular class room and know that we had a part in bringing this to pass is sufficient reward for the long hours it has taken to refine "our resources."

Annual Reports

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Shamrock Hotel, Houston, Texas
November 16, 1953

MEETINGS OF THE BOARD OF MANAGEMENT

Shamrock Hotel, Houston, Texas, November, 16, 1953

The Board of Management meeting was called to order at 9:15 a. m. by the president, Miss Henrietta McNary.

Roll Call and Proxies

Members Present:
Miss Henrietta McNary
Major Ruth A. Robinson
Miss Clare A. Spackman
Miss Florence Stattel
Miss Marie Louise Franciscus
Miss Marian Davis
Mrs. Elizabeth Jameson
Miss Marguerite Abbott
Miss Maxine Ferrell—
Miss Virginia Caskey
Mrs. Eleanor S. Owen—
Miss Marguerite McDonald
Miss Eileen Dixey
Miss Marion Crampton
Mrs. Winifred Kahmann,
past-president,
sitting ex-officio

Proxies held for:
Miss Marjorie Taylor
Sister Jeanne Marie Bonnett
Miss Patricia Exton
Miss H. Elizabeth Messick
Miss Beatrice Wade
Mrs. Louise Wade
Miss Wilma West
Dr. Sidney Licht

Not Represented:
Miss Carlotta Welles
Miss Shirley Bowing
Dr. Freemont A. Chandler
Dr. William R. Dunton, Jr.
Dr. Arthur C. Jones
Dr. Henry Kessler

Minutes of the previous meeting. The minutes of the midyear Board meeting held at the Muehlebach Hotel, Kansas City, March 15, 1953, were approved as distributed by mail.

Report of the treasurer. Financial statements and budgets for general and educational funds, Association investments, and the National Foundation for Infantile Paralysis fund were distributed to all Board members in advance of the meeting. A comparative statement of the general and educational funds, assets and liabilities, covering the past six-year period was distributed to members at the meeting.

The treasurer presented the following items which were acted upon by the Board.

1. Auditor's recommendations to the Board regarding fuller wording of motions relating to finances.

2. The executive director was authorized to re-invest the two $100 treasury bonds maturing in 1954.

3. The executive director was authorized to invest $8,000.00 of the reserve fund of $24,514.16 of the general fund in treasury bonds (G unless new H issue is preferable). This is in addition to the $10,000.00 now in savings.

4. Salary raises retroactive to September 1, 1953, were approved for the national office staff: bookkeeper, registration clerk, membership clerk, secretary to AJOT editor.

5. The executive director was authorized to grant weekly raises for the secretary to the executive director and the educational secretary if their service warrants before next September, with approval of the treasurer and executive committee.

6. It was voted to present one $25.00 bond each to Mrs. Alice Wonsor and Mrs. Gloria Kemman as a token of appreciation on termination of their services.

7. The executive director was empowered, in consultation with the treasurer, to obtain professional advice on the reorganization of office procedures in billing, memberships, etc. The bid from Mr. Carr (auditor and office management consultant) was approved subject to obtaining a second bid.

8. The Board authorized the expenditure of funds from the reserve fund for depreciation of furniture and equipment as follows: (a) $250.00-$300.00 for files as may be required in reorganization of billing methods; (b) $290.00 to replace and refurbish the office and office furniture.

9. The Board authorized an expenditure up to $200.00 for the printing of new forms and billheads as may be required in revision of billing methods.

10. The Board approved the presentation of $100.00 to the World Federation of Occupational Therapists toward expenses of the First World Congress in August, 1954.

11. The Board approved the budget for the fiscal year, September 1, 1953-August 31, 1954, with the above changes.

12. The treasurer requested that the executive committee make a study of recommended salary ranges, adjustments and perquisites in the national office, the report to be presented for action at the 1954 mid-year meeting.

Report and requests of treasurer accepted as presented and with thanks.

Report of the executive director. This report was distributed to all Board members in advance. Those items requiring Board action are herein recorded.

The need was outlined for a revision of some of our outgrown office procedures especially in regard to billing, bookkeeping methods related to it and card and record file systems of members and registrants. The Board approved the request for professional advice from an office management consultant (see treasurer's report, item No. 7 in these minutes).

Preparation of the 1954 Yearbook is about to start. The Board was asked to consider two items:

1. Listing of the P ED (professional education) carries only the OT school of the registrant while G ED (general education) carries the academic and other professional background. The question of whether all professional education should be listed under P ED rather than G ED was not approved. The Board voted that the listing remain as is.

3. Geographical listings have included hospitals whose chief occupational therapist's name appeared in the directory. The personal name of the chief and staff members were listed. This meant an incomplete geographical listing so far as inclusion of all hospitals with OT departments was concerned, as well as the inaccuracy which is inevitable when individual names are used, due to constant moving of personnel. The Board voted that the geographical listing appear with the name and address of the institution only, and that no personal names of chief OT or staff members appear.

The AOTA placement service has continued to fulfill an important place judging from requests from therapists and employers. It has always been termed a membership service but we receive requests from persons who are non-registered members. It is recommended that eligibility should include both membership and registration.

The Board voted that this be termed a membership service for registered and student members

Other activities reported included membership statistics, which show an increasing discrepancy between the number of registrants and members; Newsletter; expanded field service; literature, publications and exhibits; recruitment program; public relations and joint inter-professional activities; prospectus for 1954 rec-

ommending additional staff personnel for recruitment and publicity coordination.

Report accepted with sincere appreciation.

Report of the speaker of the House of Delegates. This report was distributed to all Board members in advance. Miss Abbott reported on House actions at the 1953 conference which were as follows:

1. It was voted to continue further study on districts in order to draw up a definite plan of operation to be presented at the mid-year meeting.

2. Constitutional revision was voted changing nominating committee chairmanship from an appointive to an elective basis.

3. It was voted to compile an SOP for OT state regional meetings.

4. It was voted to establish an annual honorary OT lectureship to be called the "Eleanor Clark Slagle Lectureship."

5. It was voted that the Western New York Association be notified by the chairman of the House credentials committee of cancellation of its membership in the House of Delegates and its affiliation with the AOTA because of non-conformance with the House of Delegates constitutional regulations.

The Board accepted the recommendation of the House and report of the speaker with thanks.

Report of the educational secretary. Miss Matthews presented a summary of her report, copies of which were distributed to members at the meeting.

Projects and activities in which the education office has engaged include evaluation of clinical practice programs for OT students; clinical training report analysis based on reports received in conjunction with the four registration examinations of 1952 and 1953 and tabulated by schools for the five major disability areas and by training center for all disabilities; comparative analysis of the clinical training report (official form) and the report of performance in clinical affiliations (experimental form). Completion of part IV of the registration examination, provision for evaluating media techniques in some manner other than present incorporation in the examination, revision of the curriculum guide, and completion of the manual for school directors are among projected projects.

The Board approved the recommendation of the education committee that all skills be deleted from the registration examination.

In case of failure in the registration examination, the Board approved a charge of $3.00 for individual analysis upon request of the student.

Report accepted with sincere appreciation of strenuous effort which it represents.

Report of the editor of AJOT. This report was distributed to all Board members in advance. Board action on questions from the editorial report were:

1. That the present style of the Journal format be retained rather than modernized with more white space which is expensive.

2. That it is unnecessary to date articles.

3. That the present style of short, concise book reviews be continued rather than fewer but longer reviews.

4. That a picture page such as activities or news item photographs be included.

The Board voted that advertisements for liquor, cigarettes and gum should not be accepted. Acceptance of advertisements for personal items was left to the discretion of the editor.

The Board voted that AJOT be mailed out under a "Return Postage Guaranteed" statement.

Listing of AJOT in the Reader's Guide has not yet been achieved. The editor requested school directors, delegates and members to ask their school, hospital and public libraries to write to the H. W. Wilson company.

There was a discussion on the ratio of advertising matter to editorial material to be carried in AJOT in terms of self-support for the magazine. Our present average is 20% advertising as compared to 40% in most newspapers and magazines. It was suggested that comment on this be included in the SOP which is being prepared.

Report accepted with appreciation and admiration.

Reports of chairmen of standing committees:

Education committee. Miss Willard reported that there were no educational matters requiring Board action other than the recommendation presented by the educational secretary regarding deletion of items about skills from the registration examination (see these minutes for the report).

Items currently under study by the central and joint education committees include: pre-OT curriculum guide; SOP for education committee; SOP for school directors; revisions in *AMA Essentials* and AOTA standards; OT definition.

Report accepted with thanks.

National occupational therapy research laboratory. Mrs. Dobranski reported on progress of this committee which has functioned as a special committee under schools and curriculum subcommittee. The committee recommended: (1) a study of structure, location and estimated costs of a laboratory; (2) evaluation of developments in research of OT equipment and devices; (3) approval to contact prominent physicians for a statement regarding the value of a research laboratory.

The Board accepted the proposal and indicated that its accomplishment would be a creditable step forward. The Board voted that this committee become a subcommittee of the special studies committee.

Registration committee. Miss Matthews distributed copies of her report to members present. A portion of the time during the seven meetings of the year was spent in reviewing examination questions regarding their application to the curriculum guide with a resulting replacement of from 17 to 25 items per part.

Total number of examinees for the past four years indicates: 1950—390; 1951—438; 1952—469; 1953—454. Item writers numbered 40 for the year.

The committee devoted time to consideration of other methods of evaluating media techniques rather than through the registration examination and accreditation of non-registered personnel.

Acknowledgements and requests for further interpretation have been received from the majority of countries to whom our letter on international reciprocity was sent.

Report accepted with deep appreciation.

Special studies committee. This report was distributed to all Board members in advance. Miss Gleave summarized action to date relative to reorganization and re-defining:

1. Sections to cover each medical area with a chairman for each and a central committee on which these chairmen will serve.

2. Development of study and testing of treatment procedures, equipment and theories with help from research consultants.

3. Solicitation of questions from field through AJOT, Newsletter and House of Delegates.

The committee recommended to the Board that:

1. A committee on establishment of a national OT research laboratory become part of the special studies committee.

2. All special studies or research projects started independently in the field should be reported to the AOTA education office and routed to special studies committee for consultation and recording.

Report accepted with appreciation.

Legislative and civil service committee. This report was distributed to all Board members in advance and was

presented at the meeting by Mrs. M. L. Crook in the absence of the chairman, Mrs. Louise Wade.

Fourteen persons representing eight states were reported present at the committee meeting. Connecticut reported satisfactory progress with their newly created advisory board. Discussion centered around variability of salary and job classifications. It was recommended that a compilation be made from salary and job specifications to be secured by the legislative committee in each state.

Resignation of the chairman, Mrs. Wade, was tendered and accepted with regret.

Report accepted with appreciation.

Permanent conference committee. Mrs. Kahmann referred to the revised SOP on conference planning which had been sent to all Board members in advance and asked for further suggestions and comments stressing necessary flexibility.

Twenty exhibits occupying 24 booths were reported for the 1953 conference.

Program arrangements and time schedules were discussed relative to improved scheduling of committee and group meetings without extension of total conference time. It was suggested that next year one day of the general sessions be devoted to separate sectional meetings or workshops running concurrently and covering the major disability areas. The Board approved this plan.

The date for the annual conference was established as the second or third week in October with flexibility for hotel arrangements or local conditions.

Future conference schedules were confirmed as follows:

1954—Hotel Shoreham, Washington, D.C. — October 16-23

1955—Palace Hotel, San Francisco—October 22-28

1956—Minneapolis, Minnesota

The resignation of Miss Josephine Davis, exhibits subchairman, was announced and accepted with regret.

Report accepted with thanks and appreciation.

Reports of chairmen of special committees:

Recruitment and publicity committee. Mr. John Redjinski outlined the principal channels of national and local activity in conjunction with the grant from the National Foundation for Infantile Paralysis for the 1953 recruitment campaign. He reported on the six major recruitment objectives, completed projects, state activities and general publicity. The committee recommended: (1) increasing emphasis on outlined objectives, (2) evaluation of the recruitment program in terms of actual "returns."

The Board voted re-designation of the recruitment and publicity committee from special to standing committee status.

Report accepted with thanks.

Committee on OT in psychiatry. Miss Ridgway's report and SOP were distributed to all Board members in advance. She displayed a poster and distributed attractive leaflets prepared by the committee presenting focus, development and projection.

The committee recommended; (1) adoption of their SOP; (2) that the committee be permitted to nominate candidates to serve on the division for psychiatric research under the special studies committee; (3) that they have the privilege of retaining their own identity as a committee in order to deal more effectively with the broad problems peculiar to the psychiatric area. For Board action on these recommendations see these minutes under committee on clinical procedures.

Report accepted with appreciation.

Committee on clinical procedures. Discussion relative to status of the committee on OT in psychiatry led to consideration of providing similar framework for each of the diagnostic areas to develop satisfactorily within the Association for their own strength and mutual benefit. It was felt that one over-all committee comprising the major disability areas and specialized groups would help avoid decentralization from the central organization and strengthen the structure and professional effectiveness of the AOTA on a national level.

The Board voted establishment of a new standing committee to encompass all clinical procedures with a coordinating chairman and five subcommittees, each with a chairman. The subcommittee chairmen with the coordinating chairman will make up the standing committee.

The Board voted that the committee on OT in psychiatry be established as part of this new committee.

Accreditation of non-registered personnel. This report was distributed to all Board members in advance and represented the recommendations of the committee under the chairmanship of Miss Stattel who was appointed at the 1953 mid-year meeting. The committee was formed to study proposed standards of training, accreditation and recognition of non-registered personnel (OT assistants and aides) in the OT program including re-establishment of an auxiliary registry.

Discussion of the report centered around the proposed terminology for a title of the register and personnel (i.e. "directory of certified occupational therapy technicians") and the feasibility of a three month course.

It was voted that the report be referred, without action from the Board, in summary form to the House of Delegates to return to the membership for their consideration and recommendation on the state level. The Board will hold it for future study pending recommendations from the House.

Report received with thanks.

VA personnel in PMR service. This report was distributed to all Board members in advance and represented the recommendations of the committee appointed at the 1953 mid-year meeting to study the Veterans Administration directives and their relationship to OT particularly from the educational angle.

Since there has been no further need for clarification of the directive during the past year, the committee recommended that no action be taken unless further problems arise.

The committee recommended that consultants on personnel policies be appointed from OTR's in each of the seven AOTA regional areas so that professional problems might be presented for evaluation and investigation and, if necessary, referred to the executive committee or Board for appropriate action. The Board felt that this service should be primarily for use of hospitals and be made available to administrators and then to the individual.

The Board voted acceptance of the report and recommended that the suggested procedure be followed with the above provisos and that the specific appointment of consultants be withheld until an immediate occasion warrants.

Fellows and the medical advisory council. This report was distributed to all Board members in advance and represented the recommendations of the committee (appointed at the 1953 mid-year meeting) to study the defining of the function of fellows in relation to the need for a medical advisory group as recommended by the education committee.

Fellows. The committee recommended that the appointment of fellows to the Association be continued in sufficient number to maintain adequate distribution. They are not to be made members of the Board of Management but will be asked to participate and contribute to our functions and problems as needed and their appointment made in the following manner: (1) nominations of candidates to be made from state associations; (2) nominations to be reviewed by OT specialty groups (psychiatry,

TB, etc.) and recommendations for appointment sent to Board; (3) the Board will have the authority for final appointment.

The Board voted acceptance of recommendations on fellows.

Medical advisory council. The Board approved the recommendations of the committee, with some alterations. The Board voted that a purely medical council be formed to include a representative from each of the six medical specialties (pediatrics, general medicine and surgery, orthopedics, psychiatry, physical medicine, tuberculosis) to serve a three year term as advisor and consultant to the Association. The selection of these representatives shall be made through a request for their appointment to the presidents of each of the specialty boards within the framework of the American Medical Association and, in psychiatry, to the president of the American Psychiatric Association.

It was proposed that the members of the medical advisory council come together approximately once a year to discuss pertinent problems of the AOTA and that they be consulted individually, either verbally or through correspondence, on matters in OT relating to their medical area. It was felt desirable to appoint the first council members from the eastern section of the country in order to facilitate ease of communication.

The Board made further recommendation relative to other professional advisors as follows: (1) that nonmedical representatives from related professional groups (nursing, social work, psychology, physical therapy, education) be invited to serve as advisors to our AOTA committees; (2) that we request the national offices of related organizations, located in areas where our annual conference is convening each year, to send a representative during the period of the conference.

Report accepted with thanks.

Constitution revision. Major Ruth Robinson reported for the chairman, Miss Ruth Zieke, that copies of the revisions had been mailed to all AOTA members 30 days preceding the annual meeting. These revisions were based on recommendations of the Board at the 1953 mid-year meeting relative to providing for a president-elect and treasurer-elect and an elected rather than an appointed nominating committee chairman. The changes would provide for a year's observation in the management of the Association's business for the president-elect and the treasurer-elect, thus insuring better continuity in Association policies.

The changes relate to Article III, Sections 1 and 2; Article IV, Section 1; Article V, Section 1; Article VI, addition of section 9. The Board accepted the report with thanks and voted the revisions as presented with selection of the second choice in Article III, Section 2. [See AJOT, VIII, No. 1, (1954) 30.]

AOTA personnel policies revision. Acting chairman, Mrs. Elizabeth Wagner, presented the revisions from which a few items had been deleted and several added including definition, duties of therapists and personnel, student training, salaries and titles and literature reference.

The Board voted approval of all changes and sent the report back to committee for further consideration on the following: (1) patient-therapist ratio; (2) salary statement regarding beginning and top salaries. The Board indicated it was not necessary to present the report for further review. It was recommended that the new version be published in an attractive format rather than mimeograph sheets.

OT volunteer training course. Material presented was not sufficient for the Board to act upon and was returned to the committee for presentation and further interpretation at the mid-year Board meeting.

SOP on committees. Miss West had distributed copies of this report at the 1953 mid-year meeting for subsequent Board study.

The Board accepted the report with thanks and recommended that the national office keep it up to date and add to it as occasion demands.

History of OT. A brief report was presented from Miss Mary Merritt stating that the committee was under organization and outlining suggested chapters. She requested that historical and developmental material be sought from the states through the delegates and Newsletter.

Report accepted with pleasure.

Manual on OT. It was announced that Miss Katherine Peabody had accepted the chairmanship. It was recommended that she coordinate with the special studies committee and newly established clinical procedures committee.

Other business

A letter of resignation, effective April 1, 1954, was received from Miss Martha Matthews, educational secretary. The Board accepted her resignation with deep regret and sincere appreciation for fine services rendered.

A letter was received from Dr. John H. Moe, Secretary-Treasurer, Clinical Orthopaedic Society, relative to their approval and support of the resolution referable to physical medicine and rehabilitation recently proposed by the orthopaedic section of the American Medical Association.

The Board acknowledged receipt of this information and requested a copy of the resolution.

The president reported on her recent naval tour which was taken at the invitation of the Secretary of the Navy and included review of some of the Navy's medical program [see AJOT, VII, No. 4, (1953) 171.] There was discussion of the Navy's proposed needs in procurement of OT's. The Board expressed interest in full cooperation.

Provision for delegate and alternates to the World Federation of Occupational Therapists was discussed. The Board voted that the office of U. S. delegate be appointive. The Board recommended that a second alternate be appointed.

The Board recommended that the mid-year meeting in 1954 be held in the Middle West sometime before the end of March.

There being no further business, the meeting adjourned at 5:45 p.m.

Respectfully submitted,
Marjorie Fish, O.T.R.
Executive Director

Fastenings . . .

(*Continued from page* 51)

c. Sew leather tabs to back of the shoe. This facilitates sliding the heel into the shoe

d. Punch holes in each side top of tongue and lace through these to keep the tongue in place

e. Long shoe horn

9. Outer Garments

a. Coats or jackets: large buttons; dolman or raglan sleeves; rayon linings instead of flannel; loosely fitting rather than fitted styles.

b. Pants: zipper crotch and pant legs

c. Mittens: Attach to coat cuffs with suspender hooks or attach them to a long tape that passes through the sleeves and over the shoulders to prevent them from being lost.

d. Hats: Avoid ties. Elastic with snap or clamp closing is preferred.

e. Overshoes: loose plastic boots with zipper or hooks should be used rather than tight rubbers

These are the basic techniques for teaching fastenings. There are other ways which may be much better for some children. The therapist should find the method that is best for the individual child. This may be found through trial and error. Before spending many months on any skill, the therapist should realistically evaluate its importance and practicality for the child. If it is unlikely that he will be able to reach his shoes, for example, his time and effort can be better spent on something more important to his independence. If buttons are going to remain a frustration and all too time consuming, substitute zippers, grippers and/or pull over clothes. With any moderate to severe involvement, eliminate as many fastenings as possible on his clothes. This will speed up his own performance and cut down on the time required by parents or nurses to dress him.

SUPPLY HOUSES

Buckles.....Laufer & Co., 461 4th Ave., N. Y. 16, N.Y.

Elastic laces.....Kugelman, 221 E. 58th St., N. Y., N. Y.

Lace Tips.....Reilly's Leather Store, 224 W. Fayette St., Baltimore, Md.

Materials.....Montgomery Ward & Co., Sears Roebuck Co.

Miscellaneous notions.....Dept. Stores, 5 & 10

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Appreciation should be given to the authors who compiled this series of articles. They are Anita Slominski, Gladys C. Rikert, Mary Lillian Phelan, Ruth Klaucke who wrote the article entitled "Feeding Suggestions for the Training of the Cerebral Palsied" which appeared in the September-October, 1953, issue of AJOT; Carol Dakelman and Alice Z. Hailperin who wrote the article entitled "The Teaching of Writing to Cerebral Palsied Patients" which appeared in the November-December issue; Gladys C. Rikert, Nancy Sloane, Gloria Sosnowski, Bernice Wiencrot who wrote the article entitled "Dressing Techniques for the Cerebral Palsied Child" which appeared in the January-February issue; and Mary-Alice Murphy, Anne S. Miller, Marjorie D. Stewart, Alice C. Jantzen who wrote the article entitled "Dressing Techniques for the Cerebral Palsied Child, Part II" which appears in this issue.

Delegates Division

KANSAS

Delegate-Reporter, Virginia L. Caskey, O.T.R.

The goal of the K.O.T.A. for the past year was to increase and stabilize membership and to further the interests of occupational therapy. A roll of 46 active, 4 associate, 2 honorary and 1 life member attests that the first part of the goal has been realized. We feel particularly honored that one of our honorary members, Donald L. Rose, M.D., director of physical medicine, The University of Kansas Medical Center, was recently elected a Fellow on the Board of Management of the American Occupational Therapy Association.

The second phase of our goal was achieved through five interesting meetings held in various centers throughout the area represented by K.O.T.A. membership and through several extra activities in which members participated. Meetings were held at Topeka, Kansas City, Wadsworth, Wichita and Lawrence. Program topics included clinical practice, gerontology, polio and retraining with the blind. One special meeting was called in order that members might meet Miss Marjorie Fish, executive director of A.O.T.A.

Extra activities included acting as hostess for a snack and coffee hour during the mid-year Board of Management meeting of A.O.T.A. held at the Muehlebach Hotel in Kansas City, March 13 to 15; attendance at a regional O.T. meeting in St. Louis, Missouri, April 25 and 26, and providing local therapists for the A.O.T.A. booth and exhibit at the Catholic Hospital Association convention in Kansas City, May 25 to 28.

Thirteen K.O.T.A. members attended the A.O.T.A. annual conference at the Shamrock Hotel in Houston, November 13 to 20, and wish to extend to the Texas Association appreciation for their hospitality and congratulations for an excellent program and a most worthwhile meeting.

OFFICERS

President ..... Sarah Gephardt, O.T.R.
Vice-president ..... Ellen Schaeffler, O.T.R.
Secretary ..... Phyllis Doyle, O.T.R.
Treasurer ..... Phyllis Harmon, O.T.R.
Delegate ..... Virginia Caskey, O.T.R.
Alternate Delegate ..... Patricia Laurencelle, O.T.R.

MASSACHUSETTS

Delegate-Reporter, Marion W. Crampton, O.T.R.

Our goal has been to carry out the association's objects as set forth in our constitution. This has been done through continuing our sponsorship of the home service committee which was started in 1949 and which is chaired by Mrs. Winifred Thompson, O.T.R. The existence of the committee carries out our first object, "to promote the use of occupational therapy." Our second object, "to advance the standards of education and training in this field," is met indirectly. From a list of registered therapists interested in administering treatment to patients in their homes, the chairman tries to fit the best person to the situation. The third object, "to promote research," has been underway for almost a year. Careful records are being kept as to the need of therapists in the home. In-coming and out-going calls, and from whom, the number of patients treated, the hours, the location, etcetera, are listed. Our last object, "to engage in any other activities that in the future may be considered advantageous to the patient, the profession of occupational therapy, and the members of the Association," is also met since the committee functions not only as a service to patients but

to therapists. All treatment is administered on a prescription basis, any therapist in the state wishing to work with patients in the home may contact the chairman and more doctors are becoming aware of and asking for this service. Our association, concerned with the financial support of this committee, sponsored a fashion show last May as one fund-raising venture.

In order to revitalize and interest younger people in the importance of joining the association, a sherry party was given in the fall for senior and affiliating students. The twenty-seven students who attended represented five schools, including the one in London, England. A panel of younger therapists stimulated much interest by discussing such timely topics as "Starting a New Job," "Organizing a Department," "Home Service O.T.," "Organizational Interests," and "Marriage and a Career."

Our association felt that it would be strengthened professionally by a medical advisory board who would act as consultants. Dr. Augustus Thorndike, Chairman, Dr. Benjamin Simon, Dr. William Reggio, and Dr. John Mackenzie have accepted appointments on the committee.

OFFICERS

President	Mrs. Irma A. Cohen, O.T.R.
Vice-president	Mrs. Eunice Burstein, O.T.R.
Secretary	Mrs. Philippa Grover, O.T.R.
Treasurer	Mrs. Priscilla Brooks, O.T.R.
Delegate	Miss Marion Crampton, O.T.R.
Alternate Delegate	Miss Inez Huntting, O.T.R.

PENNSYLVANIA

Delegate-Reporter, Corinne V. White, O.T.R.

During the past year the emphasis of the Pennsylvania Occupational Therapy Association has been toward variety in program and increasing participation among a greater number of members. The program was planned, in advance, for the entire year with the idea that there would be something of particular interest for therapists in each branch of occupational therapy.

The opening meeting was a buffet supper held in connection with a business meeting. At all meetings a period was set aside for refreshments, offering a time for socialization and exchange of ideas among the therapists from different hospitals.

A joint meeting of the Pennsylvania Physical Therapy Association and the Pennsylvania Occupational Therapy Association was held in February. The topic for discussion was the treatment of ulnar nerve injuries.

Our psychiatric meeting included a survey of occupational therapy in the twenty-one state hospitals. This was presented by Elizabeth P. Ridgway, O.T.R., occupational therapy consultant, department of mental health, State of Pennsylvania. Interesting color slides accompanied the talk.

Another meeting of particular interest was a talk "Silver Work in Scandinavia" given by Virginia Wireman Cute, O.T.R., assistant director of the Philadelphia School of Occupational Therapy.

OFFICERS

President	Elise Remont, O.T.R.
Vice-president	Phyllis Williams, O.T.R.
Secretary	Ruth V. Hirzel, O.T.R.
Treasurer	Elizabeth Murphy, O.T.R.
Auditor	Anna Moore, O.T.R.
Program	Barbara De Long, O.T.R.
Entertainment	Bernice Moss, O.T.R.
Membership	Unarda Boggs, O.T.R.
Nominating	Genevieve Lawrence, O.T.R.
Delegate	Emiko Nishino, O.T.R.
Alternate Delegate	Corinne V. White, O.T.R.

NORTHERN NEW ENGLAND

Delegate-Reporter, Eileen Dixey, O.T.R.

During 1953 the Northern New England Occupational Therapy Association lost several of its active members to other parts of the country. This has presented several problems, some of which we have been able to meet and others left unsolved. With fewer people to take the responsibility of the association and plan programs, we have decided to have only three meetings this coming year and hope that most of us can use the time that would have been spent for the fourth to attend either the Eastern Seaboard meeting in New York or one of the Massachusetts meetings.

As always, fund raising has been one of our problems. For the next few years we have agreed to levy a head tax on all active members every other year and on alternate years attempt to raise money by selling some saleworthy item.

For some time we have talked about starting a scholarship fund and have delayed doing this because of a skimpy bank account. This year we decided to delay no longer and to start a fund no matter how small. We purchased one $25.00 U.S. savings bond. Since then the fund has been added to by a group of therapists in memory of the relative of one of our officers. We feel that now this is started, ways of adding to it will present themselves and that eventually we will have something to help a prospective occupational therapist.

OFFICERS

President	Mrs. Sarah S. Stowe, O.T.R.
Vice-president	Esther Drew, O.T.R.
Secretary	Barbara Campbell, O.T.R.
Treasurer	H. Christine Swenson, O.T.R.
Delegate	Eileen Dixey, O.T.R.

SOUTHERN CALIFORNIA

Alternate Delegate-Reporter, Mary E. Pomeroy, O.T.R.

Under the chairmanship of Caroline Brinn, SCOTA is continuing its annual awards for outstanding professional work by its practising therapists. The following information is quoted from the entry blank set up by the committee and sent to each therapist.

"There are seven categories in which therapists may enter. In each category there will be three divisions: first prize, $20.00; second prize, one year's membership in the state association; and honorable mention.

"The purposes of the award are to (1) stimulate the working therapist along lines of independent study, (2) contribute to an association wide activity benefiting the group as a whole, and (3) ultimately furnish material of importance to our professional field.

"There are seven categories in which therapists may enter: physical disabilities; psychiatric; pediatric; cerebral palsy; general medical, surgical and geriatric; tuberculosis; administrative.

"Within these categories the types of entries may be equipment, record or supply system, treatment techniques (outlined on paper or with photographic study), teaching manuals or outlines, significant case study or studies, instruction aids, etc."

First prize awards in 1953 were given to Violet McCarty for her paper on "Pre-Vocational Training and Guidance for Cerebral Palsied Children;" Madeline Downs for her paper "Habit Training for Psychiatric Patients"; Ardis Gabel for her "Orthopedic Fly Shuttle Loom—An Adaptation."

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 for 3 lines; each additional word ten cents. (Average 56 spaces per line). Copy deadline first of each month previous to publication.

POSITIONS AVAILABLE

Summer camp positions open for registered occupational therapists, June 26 through August 25. Apply: The Pennsylvania Society for Crippled Children and Adults, Inc., 1107 North Front Street, Harrisburg, Pennsylvania.

O.T.R.'s wanted: staff opening in 17 state mental institutions offering a variety of opportunities and locations. Salary: $3258 - $3888. State preference in location, modality, and type of patient. Write Elizabeth P. Ridgway, O.T.R., Occupational Therapy Consultant, Department of Welfare, Harrisburg, Pennsylvania.

Supervisory openings for O.T.R.'s in large and small state mental institutions. Salary open. State supervisory experience and preferences. Write Elizabeth P. Ridgway, O.T.R., Occupational Therapy Consultant, Department of Welfare, Harrisburg, Pennsylvania.

O.T.R. to assist director of occupational therapy with established program in a state tuberculosis hospital. Excellent experience afforded. 40 hr. week; paid vacations and sick leave. Liberal retirement plan. Salary $3571-$4372. Write to: Supervisor, Occupational Therapy, N. Y. State Department of Health, Division of Tuberculosis Control, 28 Howard Street, Albany 7, N. Y.

Two positions open at Pontiac State Hospital, Pontiac, Michigan. Progressive, teaching, institution; clinical training center. Salary $3,587 to $4,363, forty hour week. Michigan Civil Service benefits. Apply to Personnel Officer.

Occupational therapist—experienced for children's treatment center. Generalized program. Current salary scale. Home for Crippled Children, 1426 Denniston Ave., Pittsburgh 17, Penna.

Staff position open for registered occupational therapist. Salary open. Pleasant surroundings and working conditions. Contact Dr. C. G. Ingham, Superintendent, Norfolk State Hospital, Norfolk, Nebr.

Occupational therapists, male and female, directorship and staff positions. Paid vacation, sick leave, retirement plan. Maintenance and laundry available. 750 bed private mental hospital. Apply Superintendent, Brattleboro Retreat, Brattleboro, Vermont.

Fairfield State Hospital, Newtown, Conn. Occupational therapists and senior occupational therapists. $3,120-$4,620; 40-hour week; well-equipped working units; good living facilities; clinical training program.

Immediate opening for assistant director, Occupational Therapy Course, Colorado A & M College, Fort Collins, Colorado. Teaching and administration duties, salary dependent on qualifications.

Assistant director of occupational therapy in a 100-bed, private, psychiatric hospital. 44-hr. week; paid vacations, holidays and sick leave. Lunch and uniform laundry provided. Liberal group insurance plan. Initial salary $3000-3300. Apply: Director of Occupational Therapy, North Shore Health Resort, 225 Sheridan Rd., Winnetka, Ill.

O.T.R. for recently opened neuropsychiatric unit of general hospital affiliated with medical school in Eastern city. Active treatment program. Salary range $3320 to $3980. State retirement plan. Write Box OT-8, AJOT.

O.T.R. for established cerebral palsy and handicapped children's out-patient clinic. School holidays, two week summer vacation. Salary open-$3000 minimum. Write Grant Birdsall, Director, Dr. Anna M. Stuart Clinic, School No. 2, 2nd and Davis Sts., Elmira, N. Y.

Staff therapist needed. Interesting functional work in field of physical disabilities with children and young adults. Close supervision by orthopedic surgeons. Highly specialized amputee training program. Educational opportunities. Pleasant modern functional workshops. All latest developments in occupational therapy practiced. OT and PT affiliating students. Starting salary for graduates without experience $3200.00 per year; for two or more years experience $3400.00 per year. Planned salary increases on merit basis. Three weeks vacation with pay. Noon meal and laundering of uniforms included. Contact Miss Aida M. Lund, O.T.R., Director of Occupational Therapy, Mary Free Bed Guild Children's Hospital and Orthopedic Center, Grand Rapids 6, Michigan.

Occupational therapist wanted to take charge of intensive program in new 64-bed hospital for chronic illness, with special emphasis on rehabilitation. Salary $3600 to $4000 depending on training and experience, Write Mr. William L. Agress, Institute for Chronic Illness, 408 Union Street, Cincinnati, Ohio.

Vacancy—occupational therapist for cerebral palsy outpatient treatment center and school. Good working conditions. Salary open. Call or write to Passaic County Elks, CP treatment Center, 1481 Main Ave., Clifton, N. J.—ARmory 4-3000. Helen Dancsisin, R.N., Director.

Akron, Ohio: Staff position open in new rehabilitation center for recent graduate or an O.T.R. Interesting variety of orthopedic disabilities. Salary commensurate with experience. Write to K. C. Keeler, M.D., Director, The Rehabilitation Center of Summit County, Inc., 326 Locust Street, Akron 2, Ohio.

Wanted—Occupational therapist to head department in small neuropsychiatric hospital, affiliated with medical school in the south. Good salary. Write OT-9, AJOT.

Wanted: OT-PT combination for director of small training school, also a chief OT for new OT department located in Mexico City. Basic knowledge of Spanish and 3 years general experience necessary. Write qualifications and state minimum salary. E. H. E. Bourchier, Chairman Polio Relief Committee, Apartado 1477, Mexico 5, D. F.

Registered occupational therapist for 220 bed, municipal, acute-general hospital. Newly organized department provides opportunity for growth and expansion of program. Starting salary $3260. One or more years' experience desirable. Supervisory ability necessary. Apply to: Dr. P. Matusow, Med. Supt., Sydenham Hospital, 565 Manhattan Ave., N. Y. 27.

Position open for occupational therapist in state mental hospital. Male therapist desired, or one who can work with male patients. Apply to Kenneth Keill, M.D., Director, Willard State Hospital, Willard, N. Y.

Registered occupational therapist (female) for large psychiatric hospital located in Oregon's Willamette Valley. Progressive program, outstanding employee's benefits, which include state retirement program, Social Security, liberal paid vacation and sick leave. Salary $3,708 to $4,548. Write Oregon State Hospital, Salem, Oregon.

Registered occupational therapist needed for treatment in community hospital program. Retirement benefits, old age pension, five day week, good salary, vacation with pay. Address Occupational Therapy Dept., Good Samaritan Hospital, 1425 Fairview Ave., Dayton, Ohio.

Occupational therapist needed to direct program in a small (17) bed psychiatric ward of a general medical and surgical hospital. Excellent educational and teaching facilities. Good salary. Write: Margaret O'Brien, O.T.R., University Hospitals, 2065 Adelbert Road, Cleveland 6, Ohio.

Occupational therapist needed for treatment and workshop program. Ideal working conditions and salary commensurate with ability. Write Mrs. E. P. Storer, Managing Director, Sheltered Workshop for the Disabled, Inc., 200 Court St., Binghamton, New York.

Wanted: Occupational therapist for 1800 bed psychiatric hospital. Starting salary $3,600 per year, no experience necessary. Excellent living accommodations for single person, 40 hour week, annual increments, paid vacations, sick leave and holidays. Contact Frances E. Jonakin, OTR, Eastern State Hospital, Lexington, Kentucky.

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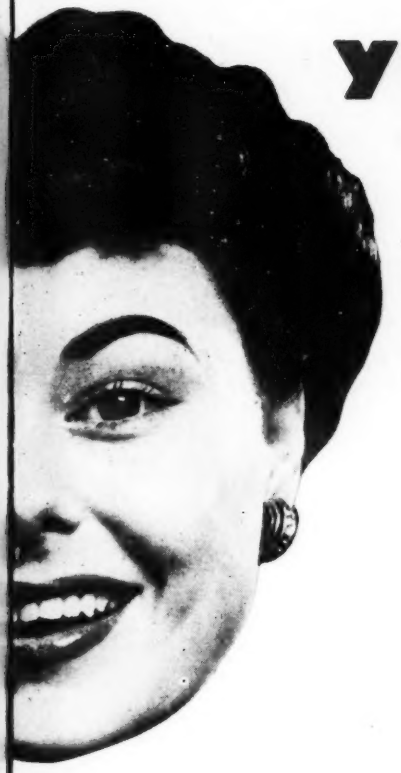

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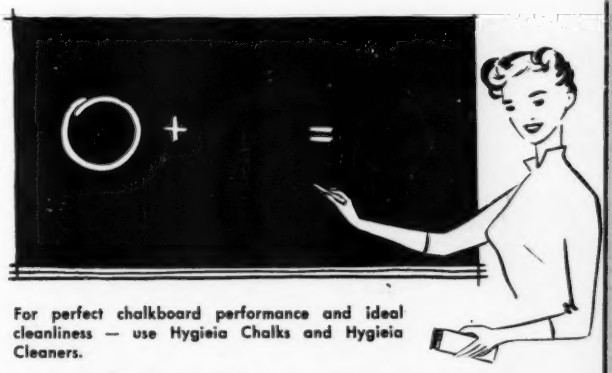

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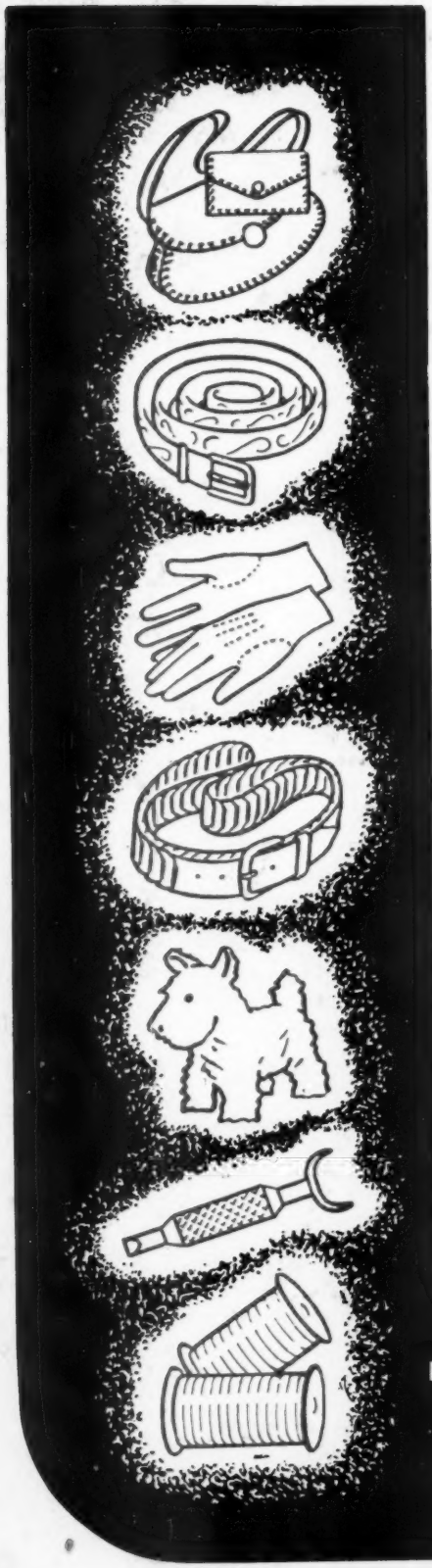

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THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

OFFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. VIII, No. 2 1954 March-April

OCCUPATIONAL THERAPY

Buyers Guide

Part II

THE AMERICAN JOURNAL
of
OCCUPATIONAL THERAPY

Official Publication of the American Occupational Therapy Association

Buyers' Guide

March-April 1954 Vol. VIII, No. 2, Part II

A FORM USED TO EVALUATE THE WORK BEHAVIOR OF PATIENTS

A Preliminary Report

A. JEAN AYRES, B.S., O.T.R.

Kabat-Kaiser Institute
Santa Monica, California

It is generally acknowledged that the role of the occupational therapist enables her to make a unique contribution to the vocational well-being of the patient. Just exactly what that contribution can be or is often remains a little nebulous. The need for additional investigation of this aspect of occupational therapy has been expressed frequently.

The Kabat-Kaiser Institute located at Santa Monica, California, is set up for the rehabilitation of patients with neuromuscular disorders. The vocational problems of patients are handled by the state bureau of vocational rehabilitation utilizing the recommendations and contributions of the Kabat-Kaiser vocational rehabilitation board. The counselor from the bureau of vocational rehabilitation is a state employee affiliated with the institute. The vocational rehabilitation board is made up of this counselor plus institute employees including the medical staff and representatives from the departments of nursing, physical therapy, occupational therapy, social welfare, psychology, administration and a coordinator between the state office and the institute.

Each representative contributes to the general knowledge of the patient according to his own field. The occupational therapist felt that he could not contribute anything unique along the line of special interests and abilities or psychological information which the psychologist or counselor's psychometrician could not do just as well or better with their battery of tests. Contributions of this type seemed more along the line of confirmation or elaborations of a subjective nature. It has evolved that the occupational therapy department could contribute two types of information the other departments could not. These were the physical capacity of the patient to engage in work activities (particularly from the upper extremity standpoint) and an on-the-spot evaluation of behavior in a work situation.

The work capacity could be deducted from the functional activity records kept on every patient. The person best qualified to evaluate work behavior is the therapist working directly with the patient. It is sometimes a problem for that therapist to evaluate a patient in these traits in objective terms that can be carried by the representative of the occupational therapy department to the meeting of the vocational rehabilitation board. For that reason, a form which the therapist could fill out on the patients scheduled to come before the board seemed to meet the need.

The questions asked on the form were chosen because the therapist had an opportunity to observe and judge the behavior trait questioned and also because it was felt the items listed referred to attitudes or habits of vocational significance. The questions, while applicable at this treatment center, would not necessarily fit any other situation.

Note that the questions are worded in such a way as to encourage objectivity and discourage generalizations which a therapist is not qualified

EVALUATION OF WORK BEHAVIOR OF PATIENTS AS OBSERVED IN OCCUPATIONAL THERAPY

Patient's name *Joe Doakes* Therapist *Jane Doe*

Please check the following items of work behavior of the above patient, basing your opinion on behavior which you have observed while the patient was working in occupational therapy.	90-100%	70-90%	30-70%	10-30%	0-10%
1. Attends O.T. regularly (legitimate excuses considered).	X				
2. Arrives in the department on time (legitimate excuses considered)	X				
3. Is working soon after arrival in the department (physical disability considered).		X			
4. Handles tools with as much care as he is physically able.		X			
5. Puts project and tools away when treatment time is over (disability considered)		X			
6. Tries to do the best work he is capable of doing.		X			
7. Does not waste materials when he uses them.		X			
8. Goes ahead "on his own" when there is nobody to help him immediately.			X		
9. Tries to figure things out for himself before asking for help.				X	
10. Pays attention when you give him instructions.		X			
11. Remembers instructions once they are given.		X			
12. Persists in completing project even though he encounters some difficulty.			X		
13. When severely frustrated by work situations, remains patient.		X			
14. Plans his work himself rather than relying on therapist.				X	
15. Looks ahead when planning project.			X		
16. Shows a sense of humor.		X			
17. Mixes informally with other people who are in the shop.	X				
18. Is willing to share working space or tools when other patients need them.	X				
19. Tries not to disturb the treatment of other patients through excess demands on therapist.	X				
20. Is alert to the possible disturbance of other patients by noise, dust, etc.	X				
21. Presents a cheerful appearance.	X				
22. Is able to accept change of treatment time without being upset.	X				
23. Will listen to other points of view.	X				
24. Accepts authority of therapist.	X				
25. Other patients enjoy having this patient around.	X				
(multiplied by)	4	3	2	1	
	44	29	6	2	
total score				81	
date				9-17-53	

Remarks: *A good worker. Likable but seems to need a lot of supervision. Does gross work better than fine. Not particularly dexterous though he tries.*

to make. A therapist is not asked to state whether or not a patient seems to be too dependent. He is, rather, asked to state how much of the time the patient works "on his own" when there is nobody to help him and how much of the time he tries to figure things out for himself. The therapist is not asked to evaluate whether or not the patient might resent authority. He is asked to record how often the patient accepts the authority of the therapist and how often the patient will listen to other points of view.

After all the questions have been checked according to the percentage of time, the number of checks in each column is multiplied by the number underneath that column. When these figures are added, a total score is obtained on the basis of 100 being the score for the person with perfect work behavior. Thusly, if a patient rated a 90 to 100% check on each item, 25 multiplied by 4 would be 100. Sample scoring is shown on the form.

It is recognized that this test is valid only for that which it tests, namely, work behavior of patients while receiving occupational therapy. It is hoped that in time the results of the form will be correlated with work behavior of the same patients in the actual employment situation. This, of course, is essential to the ultimate value of the information. Since so much more is needed to be known in this field, it is hoped that other therapists will also contribute their ideas on how the occupational therapist can work toward the vocational well-being of the patient.

The dates for the convention in 1955 to be held in San Francisco are October 22-28 instead of the earlier dates quoted in the committee reports in the last issue of the Journal.

SUMMER WORK CONFERENCES

The Center for improving Group Procedures, Teachers College, Columbia University, announces three summer work conferences. The first, to be held July 6-16, is entitled "Developing Student Leadership" and will endeavor to show how students can develop participation skills for school or community, democratic citizenship through self-government and effective student-faculty relations.

The second conference scheduled July 19-30 will be "Improving Staff Relations." This workshop will discuss ways of improving staff morale, interpersonal relations, staff meetings and communication.

The last conference, August 2-13, is entitled "Planning Workshops and Conferences" and will present plans for more effective staging of conference and workshops and how to achieve effective conference participation.

For details about any or all of the workshops write:

Three Key Summer Work Conferences
Center for Improving Group Procedures
Box 304, Teachers College, Columbia University
New York 27, N. Y.

ASSISTIVE APPARATUS FOR THE PARALYTIC HAND

DUANE A. SCHRAM, M.D.[1]
ROSE M. ELLIOTT, O.T.R.[2]
ROBERT G. WILSON, M.A.[3]
RANDOLPH N. WITT[4]

This presentation will be limited to an elastic device for apposition of the thumb and two types of spring tension for the thumb and fingers: one for flexion and the other for extension. The use of this apparatus, as is found in most other types of apparatus for paralytic conditions, is mainly for function, but secondary considerations should also be recognized. Also, as with most apparatus for similar conditions, there are favorable and unfavorable combinations of muscle weakness which will influence the success of operation.

Figure No. 1, A

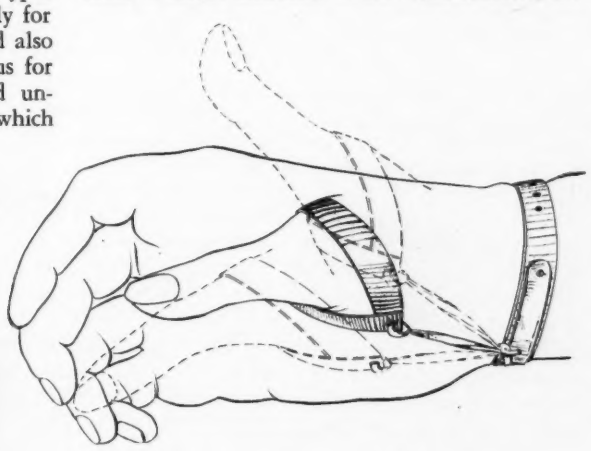

Figure No. 1, B

When a device is designed to assist a body part through a useful range of motion, there are other treatment measures involved in this motion. In assisting a part such as a finger it is apparent that an increased range in physiological position may be attained which would be unattainable without the device. In so doing the joint, or joints, maintain mobility and it is possible in some cases, by strong tension, to actually increase the range by traction on the offending tightness or contracture. By keeping the joint, or joints, well mobilized it is found that reconstructive surgery, if indicated in the future, will be destined for a more favorable functional result. Finally an assisted motion will allow a non-functional muscle group to actively participate in a dynamic motion previously unavailable.

OPPONENS ELASTIC AID

In Figures No. 1, A and B, the Rosenauer thumb assist (so named after the first patient for which it was designed) utilizes elastic tension to pull the thumb forward from the hand and into a position of apposition with the fingers. The tension and line of pull is adjusted in each individual case depending on the imbalance in the muscles of the thumb. This dynamic assist is most practical for those patients who have some ability to extend and flex the thumb but have poor apposition. In order to assure assistance to the weak muscles, the patient's activities must be supervised or incoordination could result if too vigorous action is attempted during the initial training.

HUNTER SPRING EXTENSION ASSISTS

The Hunter Neg'ator springs[5] are manufactured from spring steel and exert any constant force desired, dependent on their size. In making assists for extension of fingers and thumbs we have used the small ones varying in strength from about one to six ounces. Their compactness and their constant force, regardless of the amount of extension or deflection of pull, gives them an advantage over rubber band extension assists. The free end of the spring is attached to a leather cuff encircling the finger or thumb and the coil runs freely over a small spindle fastened to the hand-splint in a position to balance the pull of the opposing muscle. The correct size of spring should be chosen which

1 Medical director, Gonzales Warm Springs Foundation Hospital, Gonzales, Texas.
2. Director, Occupational Therapy Department.
3. Research and design specialist.
4. Certified orthotist.
5. From the Hunter Spring Co., Neg'ator Division, Lansdale, Pa.

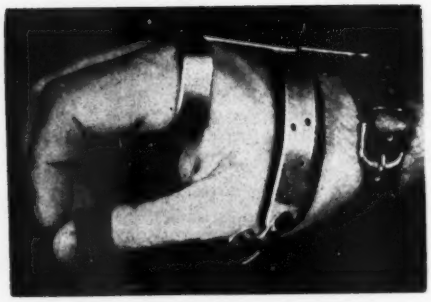

Figure No. 2, A

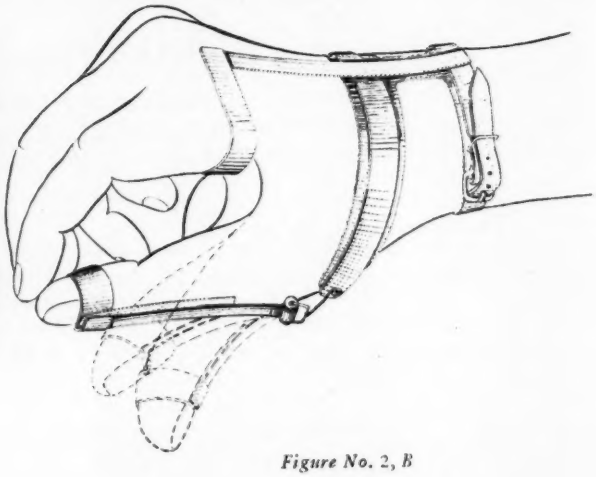

Figure No. 2, B

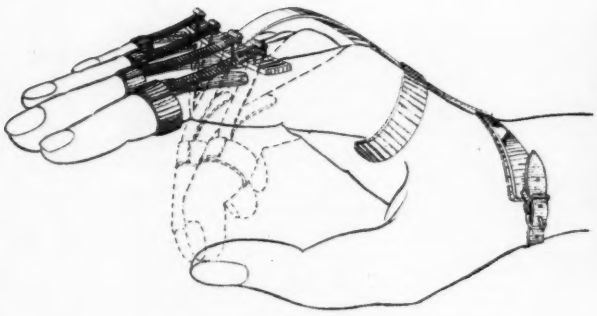

Figure No. 3, A

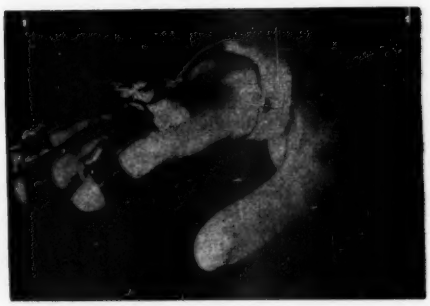

Figure No. 3, B

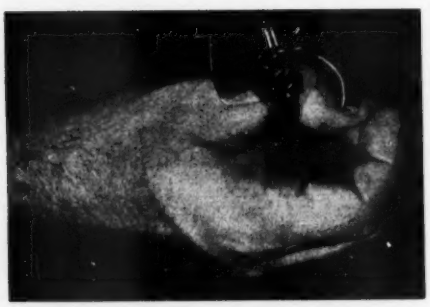

Figure No. 4, A

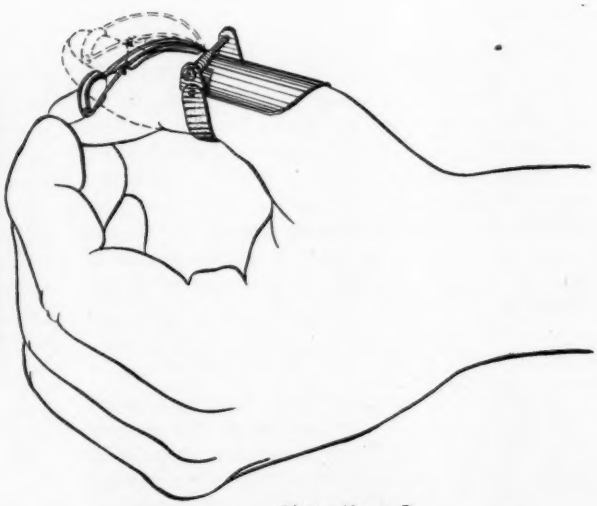

Figure No. 4, B

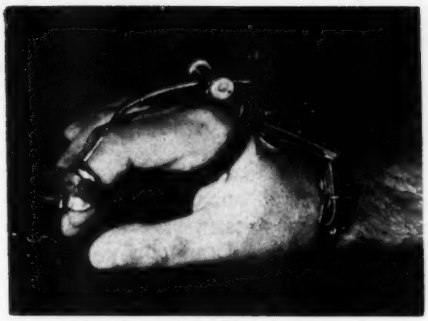

Figure No. 5, A

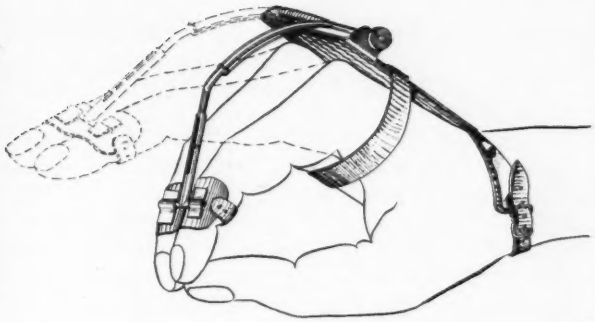

Figure No. 5, B

will exert the *minimal* force necessary to assist the weak extensor through a functional range.

Figures No. 2, A and B, illustrate the Hunter Spring extension assist to the thumb which may be used when there is functional strength in thumb flexion but weakness in extension, especially in the long extensor. When this imbalance exists without some assistance, the thumb may lie in a flexed position against the palm. In this unnatural position function is limited and deformity will result.

Figures No. 3, A and B, illustrate the Hunter Spring extension assist to the fingers. The free end of the spring is attached on the dorsum of either the distal or middle phalanx depending on the relative strengths of the profundus and sublimus. This assist allows the patient to make use of whatever functional grasp he has by giving him the necessary power of release.

PIANO WIRE SPRING FLEXION ASSISTS

In this apparatus there is a rotary force between the two ends of a cylindrically coiled piano wire spring which varies according to the size of the wire, the size of the coil and the number of turns. This torque action of the spring in the flexion assist is similar to the action found in the pinch of a spring clothespin.

Figures No. 4, A and B, show the piano wire spring thumb flexor assist which flexes the distal joint of the thumb. In patients with a hyperextended distal phalanx and loss of power of the long flexor of the thumb, grasp between the thumb and fingers is difficult especially in cases where finger flexion is also weak. The tension of the spring is so adjusted that the force is sufficient to flex the joint but not so strong as to inhibit coordinate extension. The pressure is applied against the thumb nail by a small leather covered metal bridge of wire, which rides proximally in flexion and distally in extension. In addition to increasing function, this device aids in increasing range of flexion of the distal joint when this range is limited and the return of strength in the long flexor is encouraged.

Figures No. 5, A and B, exhibit a piano wire spring flexion assist to fingers, used when there is loss of power in flexion but functional strength in extension. There is a sliding mechanism in the bar to make up for the difference in length between the position of the fingers in flexion and in extension. The strength of grasp is determined by the adjustment of the spring and is limited by the amount of resistance which the finger extensors can oppose and the pressure which can be applied to the dorsum of the fingers. A very strong spring is not practical but it is usually possible to apply enough pressure to enable the patient to adequately manage writing, eating, shaving and even opening a door.

CONCLUSION

It should be emphasized here that an accurate muscle examination is essential for evaluation and proper prescription. The apparatus described is not indicated for all weakness in the hand but rather limited to the specific weakness stated in each case. It follows that for efficient operation of the devices considered, accurate fitting and frequent readjustment is necessary in every case.

THE OCCUPATIONAL THERAPIST AS THERAPIST[1]

ARTHUR BURTON, Ph. D.[2]

There is a developing trend in the state psychiatric hospital which carries tremendous import for the occupational therapist of the future. This trend is only vaguely discernible, but nevertheless very real.

Occupational therapy in the psychiatric hospital probably began as a need to fill a void in the patient's life. This was the practical necessity of keeping the patient from insidious deterioration through work or activity of some sort. In its most primitive form it was simply activity of any kind without relation to the patient's personality needs, interests or the individual treatment program. It was assumed that engaging the patient in some job was curative but in what manner was not exactly known. It is interesting that many of the assumptions which underlie present day industrial therapy still revolve around this concept.

At the second level of development the occupational therapist and the physician became dissatisfied with activity which merely filled time and in negative fashion was justified by keeping the patient from further decline. A positive program was sought which permitted the therapeutic use of creative expression and which tied in more intimately with the prescription of the psychiatrist. The occupational therapist therefore developed a wider range of media (utilizing not only ceramic, plastic, wood, leather and similar materials but also music, recreation, books, etc.) and thus offered more challenging activity to the patient. The diversity of the program also provided in better fashion for the individual differences found among the patients. On a theoretical level the implied hypothesis was that the intricate and skilled manipulation involved in these newer activities was somehow more curative than gross work which required less skill. The obvious excellence and commercial value of the product which resulted further enhanced the feeling that something basically curative was involved.

The third level of development of occupational therapy involves the pressure of recreation, music, drama, the library and similar areas for recognition as distinct therapeutic forces and establishment in their own right as departments with specialized training requirements. While there are objections to such diversification, its ultimate effect has been to confine the occupational therapist even more closely to his manipulative media and thus limit his to the therapy inherent in the materials. This, I conceive, as the present stage of occupational therapy.

The fourth and future status of occupational therapy, as I see it, involves in placing the stress upon the therapist rather than upon the media. Now there is nothing inherently wrong with media. Behavior does not take place in a vacuum and media are needed to stimulate thought and action. However the emphasis on media seems to me a displacement of curative possibilities inherent in occupational therapy. Patients do not get well because of set perceptual-motor operations but because of human interaction—patient and therapist. A medium serves to bring both together on some common ground and where it becomes an end in itself, it is self-defeating.

If we accept the genesis of emotional disorders as basically involving faulty identifications in early life, then the process of treatment becomes corrective experiences with people who can provide new identifications and in this way further more satisfying living. This is essentially the process of psychotherapy and no amount of intervening media can substitute for the interpersonal experience with the therapist.

Experience indicates insofar as the occupational therapist accepts himself as a professional person doing treatment and his media as merely an adjunct, so is he successful in fundamentally assisting in the maturation of the patient. Where he cannot do this, the patient usually leaves with little except the object he has created.

Becoming a therapist in the above sense does not come about merely by a statement of intention. There are resistances to such a role and these operate on every level of therapy from the psychiatrist down. There are unconscious and irrational elements in all of us which we fear, and it it is painful to see them mirrored in our patients. Many of us also cannot free ourselves of the idea that patients are somehow innately different from us, otherwise they would not be patients. Anxiety in others similarly tends to make us anxious, no matter how objective we attempt to be. It is thus easy to see that the mantle of the psychotherapist is not easily assumed.

The occupational therapist may raise the ques-

1. Abridged from an address given to the Northern California Occupational Therapy Association, April 10, 1953. Acknowledgement is made to Mrs. Doris L. Taggart, O.T.R., for her kind assistance

2. Chief Psychologist, Agnew State Hospital, California Department of Mental Hygiene, and Santa Clara County Hospital, San Jose, California

tion: "After all, we are not psychiatrists . . . we cannot be expected to do treatment of this sort." One must say here that therapy is generically the same—it has only levels of intensity upon which professional people operate. All patients have conflicts and anxieties which they bring to every situation in the hospital and one must deal with them in some way. This is true whether one is a psychiatrist, a psychiatric social worker, clinical psychologist or an occupational therapist. In the state psychiatric hospital there are not now, and promise not to be in the near future, sufficient psychiatrists to provide verbal therapies for our patients and the burden will largely fall upon the shoulders of medical ancillary personnel. The most that we can hope for are sufficient psychiatrists for prescription and supervision of treatment programs.

If all the therapists deal with the anxieties of the patients on the level of their training, it is necessary then for the occupational therapist to clarify his role and give proper emphasis to himself as a therapist. To do this certain obligations are involved which call for professional stature and growth. These are requisites which all therapists must meet who set out purposefully and systematically to help patients.

Not the least of these is a willingness to know one's self—to examine one's strength and one's weaknesses. This is necessary in order that the therapist's own personality needs are not projected upon the patient, and that he not become threatened by the close relationship which develops. It is not that the therapist need necessarily become a more perfect person, but that he be able to express his own special emotional warmth with the security and self-assurance which comes from self-understanding.

Here at Agnew State Hospital we have made a small beginning in this direction. On a voluntary basis the members of the occupational therapy department meet one hour weekly with the author as group leader. No lectures are given and there is no agenda. The meetings are structured as simply an opportunity for the therapist to bring up any matter involving the treatment of a patient. The group leader focuses the discussion by clarification of ideas and feeling and at all times keeps the role of the therapist in view.

The early experience with this form of self-understanding was not necessarily favorable. Therapists expected and even insisted upon lectures from the group leader. They seemed somewhat embarrassed by the permissiveness of the meetings and that they were accepted as psychotherapists. There was some conjecture that possibly this was another administrative device for testing their efficiency, even though administrative personnel were not included. Gradually, however, these feelings diminished and the situation was accepted as a group opportunity for growth as a therapist. It should be said that in two instances the occupational therapists could not face up to the potentialities of the experience, or could not find it meaningful, and dropped out of the group.

This paper is not intended as a report of my experiences in group therapy with occupational therapists. It is merely to state that the benefits from this preliminary work were such as to encourage its further exploration. It revealed that occupational therapists were eager and ready to use themselves and their media in the fashion of the psychotherapist but were confused about their roles and lacked specific instruction. In many cases certain gifted therapists had attained dramatic success through trial and error efforts on their own part.

It is essential that the occupational therapist of the future not only be trained in the understanding of the interpersonal situation but in group dynamics. Much occupational therapy occurs in groups and group therapy can be as effective or more effective than individual therapy. Patients reinforce and support each other. Their insight can become the insight of other patients. Also more patients can be reached in this way. The therapist must understand the group situation and foster it for therapeutic purposes.

It may seem in retrospect that I have put too much of a therapeutic burden upon the occupational therapist. I think they can and are ready to assume it. I think that psychiatrists and patients will demand this of them and they cannot fall short in this regard. If occupational therapists will accept themselves as psychotherapists they can grow and make even greater contributions to the patient's welfare. The results will be contingent upon whether academic and collegiate training centers of occupational therapists recognize these dynamic trends in the psychiatric hospital and plan for them.

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Magna Engineering Co. Woodworking tools.
Medical Fabrics Co., Inc. Elastic bandage
Moore Engineering Co. Knifork.
National Picture Slide
Profitkraft Co. Artificial flower supplies.
Remington Rand Co. Typewriters
Schrader Instrument Co. Motor accessories.
Self Ease Units. Bathroom frames
E. H. Sheldon Equipment Co. Furniture.
Thera-Plast Co. Silicone
Tower Co., Inc. Aire-cast bandage
Typewriting Institute for the Handicapped. One handed typewriters.
Vernon-Benshoff. Ortho-roc casts
Weber Costello Co. Display boards and clips.
H. Weniger. Bunnell splints
X-acto Crescent Prods. Handicraft Tools and Kits.

Have You Tried

Are you looking for some inspiration? Ideas in the doldrums? Then send for your free copy of "Creative Crafts with Crayola" offered by Binney and Smith. Full of gayly illustrated ideas that can be easily executed.

* * *

One of the newest Picture Craft paintings is directly from Hawaii. It is called Tropical Net Fisherman, and shows a Kona fisherman casting his net into the Pacific Ocean, with a background of coral sand, bright blue water and a colorful horizon. The Grossmans, owners of Picture Craft, took many color slides to fully interpret the true actions and background of the Tropical Net Fisherman. The Grossmans are not satisfied to copy a picture, but must see with their own eyes what local color or background is necessary to portray the subject faithfully.

* * *

If you are always interested in new activities that would appeal to male patients, you have already noted the ad for a beginner's kit in electricity being offered by the Crow Electri-Craft Corporation. These kits come equipped with a 275 page manual expressly written for beginners with no experience.

* * *

Many of you must have missed the very interesting offer made by Reddigraphs (weaving patterns) in the 1953 issue of the Yearbook so I suggest you send for a brochure—you'll find it most interesting. Write Miss Winogene Redding, 67 Winthrop Ave., Wollaston 70, Massachusetts.

* * *

A new white pen with gold cap has been specifically designed for members of the medical and allied professions by the B. B. Pen Company of Hollywood, California. It not only is attractive but also writes very well.

(*Continued on page* 92)

PLANNING THE PSYCHIATRIC PHYSICAL PLANT

MARGUERITE E. BICK, O.T.R., DIRECTOR
Occupational and Recreational Therapy
Larue D. Carter Memorial Hospital
Indianapolis, Indiana

The plans in this article are designed to meet the needs of the state or private hospitals whose acute patient load would not be less than fifty and not more than two hundred. The shop plans are for the acute patients who are on an intensive treatment program. The needs of the continued treatment patient case load requires another type of program. The patient who is ready for industrial therapy leaves the acute treatment area for the next step in his rehabilitation program.

These units include the following group of skills: creative and manual arts, activities of daily living, recreation, music and education. The recreation and music facilities should be adjacent to or close to the shop area.

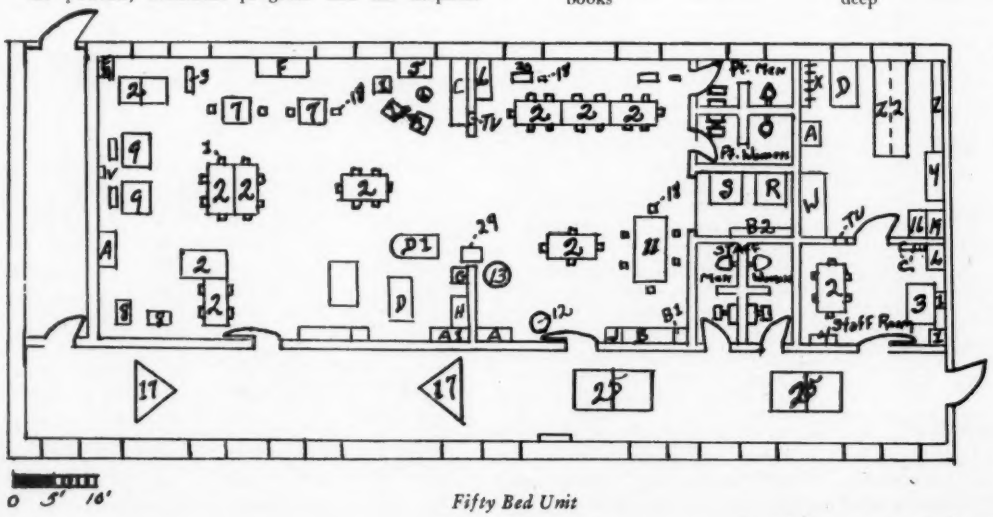
The following general directions are recommended:

1. The director's office should be in the same area as the rest of the administrative staff.
2. Good ventilation and light. Thirty-five foot-candles at table height is recommended and can be higher for some work.
3. Furniture such as tables, chairs, workbenches should be movable because it is important to fit your furniture to meet the needs of the patients and therapist.
4. Pastel green tile walls between the shops; the staff room and interview room, and the corridor wall into the staff room forty-two inches high with glass partition to ceiling.
5. Forty-two inch doors in the whole area.
6. Sufficient space in storeroom to make a small dark room if this is a planned activity.
7. The equipment list included has been found satisfactory in the two-hundred bed hospital. Some additions may be necessary depending on the needs of the patients, treatment program and the hospital.

Key for floor plan:

1. Chair
2. Table
   2-1. Table for ceramics (34" high)
3. Desk
4. Bulletin board
5. Couch
6. Coffee table
7. Woodworking bench
   7-1. Woodworking bench with storage bins
8. Sewing machine
9. Loom
10. Easel
11. Potters wheel, hand
12. Wedging stump
13. Potters wheel, foot-pedal
14. Cart
15. Ping pong table
16. Wagon
17. Shuffle board
18. Stools
19. Record player
20. Bins on rollers

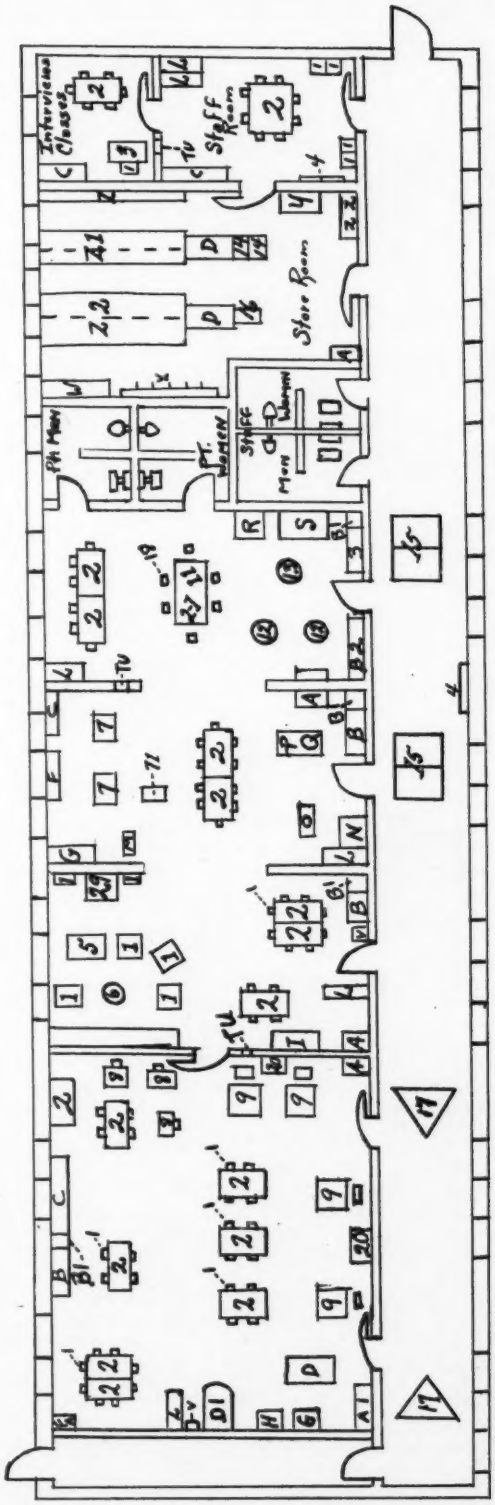
A. Sink, cabinet
   A-1. Double drain sink, cabinet
B. Built-in-cabinet, sliding doors
   B-1. Broom closet
   B-2. Open shelves
C. Bookcase
D. Counter, metal, sliding doors
   D-1. Counter, open shelves
E. Open shelves (2), for spices, canisters, cookbooks
F. Metal cabinet for flammable material and woodworking tools and stock supplies
   F-2. Metal cabinet for flammable material
G. Electric ice box
H. Electric stove, 220 electric outlet
I. Leather rack
J. Metal cabinet on rollers for leather, and jewelry tools
K. Wood rack
L. File cabinet
M. Electric jig saw
N. Type case
O. Imposing table
P. Table for press
Q. Hand printing press
R. Kiln, 220 electric outlet if available
S. Wet box
T. Telephone
U. Pass window
V. Wall telephone
W. Wall wood rack
X. Reed rack
Y. Rack for ball, bats, rackets
Z. Cabinet, metal, sliding doors, 12" deep
   Z-1. Cabinet, metal, sliding doors, 18" deep
   Z-2. Cabinet, metal, sliding doors, 24" deep



Fifty Bed Unit

Equipment list:

2 sewing machines, foot pedal, table model
1 sewing machine, electric, table model
2 electric irons
2 ironing boards, metal
1 sander, electric hand, Model 2000
1 scroll saw No. 40-205, standard four speed motor and switch No. 62-110, Delta
3 typewriters, standard size
3 typewriter tables with rollers
1 saw, cross cut, 24", 8 points per inch
1 saw, rip, 24", 6 points per inch
1 saw, back and miter box
1 saw, compass 12", 8 points per inch, interchangeable, 3 blades
1 saw, back, extension frame with 10" blade
1/2 dozen saw back blades 10"
1 pliers, lineman's 7"
2 pliers, chain nose 6"
1 pliers, side cutting 6"
2 pliers, cutting, diagonal
1 nippers, end cutting 6"
2 mallets, rawhide 2" x 3 5/8" head, 9 1/2" handle length, 8 1/4 oz.
1 level, 12"
1 gauge, marking
1 brace, rachet, bit 8" sweep
1 brace, counter sink
1 set drills, bitstock
1 hammer, ball peen
1 hammer, 8 oz.
1 hammer, 13 oz., ball faced, curved claw
1 hammer, 7 oz., ball faced, curved claw
1 hammer, 16 oz., ball faced curved claw
1 hammer, magnetic tack
2 knives, putty
1 compass, eagle
4 compass, pencil
1 square, combination
1 square, steel
2 drills, hand
2 sets drills
2 files, cabinet, half round 10"
2 files, smooth mill, 10"
2 files, slim taper, 10"
2 files, saw, 10"
2 files, flat bastard, 10"
2 files, round bastard, 10"
2 rasp, cabinet, half round
2 sets files, needle, swiss patterns, jewelry
2 screw drivers, blade 3", shank 7/32"
1 screw driver, blade 4", shank 1/4"
1 screw driver, blade 6", shank 9/32"
1 screw driver, blade 8", shank 5/16"
1 snips, tinners combination 10"
3 pairs shears, pinking 10"
1 doz. pair scissors, 8" pointed
2 doz. pair scissors, 4" blunt
4 tape measures, metal
6 yard sticks
1 doz., rules, 12" metal edge, scale 1/16", flat
2 dividers, spring, standard
1 rule, folding, 6'



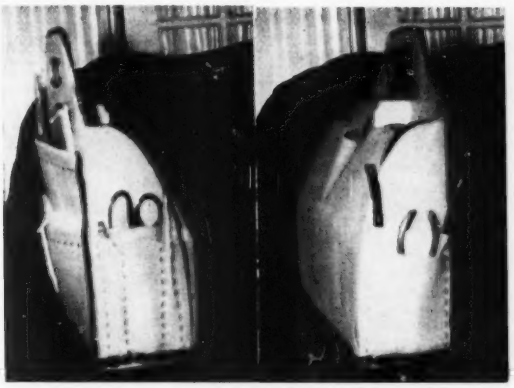
Two Hundred Bed Unit

1/2 doz., saw, coping frame
1 gross saw, coping blades
1 wrench, adjustable and crescent 8"
1 wrench, adjustable and crescent 10"
1 set wrenches
1 doz., clamps, C, super jr., 3"
1 doz., clamps, C, super jr. 2"
2 oil stones 2" x 8" x 1" combination
2 planes, block, 5 1/2"
2 planes, jack, smooth, 9"
1 plane, rabbet, 8 1/2"
3 awls, scratch, 3 1/2" blade
1 nail set 1/32"
1 nail set 2/32"
1 nail set 3/32"
1 nail set 4/32"
1 set chisels
1 chisel, cold 5/8"
2 brushes, hand wire
4 vises, table
3 oil cans
4 hand screws, maximum opening 12"
4 bar clamps, 48" length
1 level, slide T, 8"
1 square, try and miter, 8"
2 hand grinders, heavy duty, 6" x 1" grinding wheel, medium grit, adjustable tool rest
1 soldering iron, length 10 3/4", 1-5/16 lip
2 dusters, bench
2 brayers, 4"
1 doz. spatula
1 slab, heavy plate glass, mixing 9" x 6"
2 sets knife for cutting linoleum blocks
1 set knife, wood carving
1 spool rack, folding
2 looms, 10" inkle
4 shuttles for inkle loom
1 loom, 21" reed, 4 treadle, sectional warping beam
2 loom, 45" reed, 2 treadle, sectional warping beam
1 loom, 45" reed, 6 treadle, sectional warping beam
4 loom benches
1 doz. looper frames
1 type cabinet, wall
1 imposing table
1 pilot printing press
2 chases, semi steel, for pilot press
1 font reglet and furniture
1 can benzine, pint size
1 brush, stapled benzine, oval block
2 type sticks, pica composing, 6" x 2" stainless steel
2 type sticks, pica, composing, 10" x 12" stainless steel
6 galleys, pressed steel, 8 3/4" x 13", rust proof
1 doz. pins, original steel gauge
4 tubes ink, printing, amtyce job black, 1/4 lb.
6 quoins, challenge No. 1
6 quoins, challenge No. 2
2 key, challenge quoin, style C No. 1
2 key, challenge quoin, style C No. 2
1 mallet, printer's
1 planer, proof 3 1/4" x 8" with leather top
1 planer, midget type, 1 3/4" x 3"
1 brayer, 5" handy, with cost roller
1 set Veseial Aide for instruction in printing, 24 charts, 11" x 14"
1 font Century Schoolbook, 8 point
20 lbs. Century Schoolbook, 10 point
1 font Century Schoolbook, 12 point
1 font Century Schoolbook, bold 10 point
1 font Century Schoolbook, bold 12 point
1 font, Century Schoolbook, bold 18 point
1 font Century Schoolbook, bold 30 point
1 font Century Schoolbook, bold 48 point
1 font Gothic, riglet copper plate 6 point No. 2
1 font Gothic, riglet copper plate 8 point No. 4
1 font Gothic, riglet copper plate 12 point No. 6
1 font Gothic, riglet copper plate 12 point No. 7
1 font spaces and quads, 6 point
1 font spaces and quads, 8 point
10 lbs. spaces and quads, 10 point
2 font spaces and quads, 12 point
1 font spaces and quads, 18 point
1 font spaces and quads, 30 point
1 font spaces and quads, 48 point
14 lbs. leads, 2 point labor saving, 4 to 25 ems.
25 lbs. slugs, 6 point labor saving, 4 to 24 ems.
5 lbs. rule, 2 point, metal
1 can, oily waste
1 paper cutter, 12" x 12"
1 hammer combination
2 mallets, rubber
1 T-stake
4 pliers, long nose, round
2 pliers, flat
2 viseo, hand, wood handle
2 knives, stick
2 knives, X-acto, 1 blade
Educational Charts, Education Dept., Stanley Tools—No. 52-54, 101, 103, 108-122, 126-131
1 punch, slitter
2 knives, shiring, bevel point
1 snap set
1 snap attaching set
1 setter, eyelet, punch type
1 space marker
3 squares, steel
2 awls
2 chisels, thonging 3/32"
1 mallet, hickory
6 tools, modeling, assorted
2 woodburning tools
1 doz. pkg. needles, Embroidery No. 5-No. 10
1/2 doz. pkg. needles, Tapestry
6 doz. needles, knitting No. 5 single point
1 doz. needles, knitting No. 1 double point
1 doz. needles, knitting No. 2 double point
2 doz. needles, crochet, heaviest wooden
1 doz. needles, crochet, plastic No. 6
1 doz. needles, crochet, plastic No. 9
1 doz. needles, crochet, steel No. 12
1 doz. needles, crochet, steel No. 5
1 doz needles, crochet, steel No. 00
1/2 doz. brushes, camel hair, water-color, No. 2
1/2 doz. brushes, camel hair, water-color No. 4
1/2 doz. brushes, camel hair, water-color No. 6
1/2 doz. brushes, stencil No. 3
1/2 doz. brushes, stencil No. 5
1/2 doz. brushes, white bristle, oil flat No. 4
1/2 doz. brushes, white bristle, oil, flat No. 6
1/2 doz. brushes, bright, Russian sable, oil No. 4
1/2 doz. brushes, bright, Russian sable, oil No. 6
1/2 doz. brushes, round red sable, oil No. 4
1/2 doz. brushes, round red sable, oil No. 8
1 doz. brushes, 1 1/2" Matercraft
1 doz. brushes, 2" Matercraft
1/2 doz. brushes, 2 1/2" Matercraft
1 doz. brushes, 1/8" One stroke Show Card
1 doz. brushes, 1/2" One stroke Show Card
1 doz. brushes, 5/8" One stroke Show Card
1/2 doz. brushes, 1/2" round, varnish
1/2 doz. brushes, 1" round, varnish
2 allsteel storage cabinets
1 allsteel storage cabinets for tools
1 allsteel storage cabinets for tools on rollers
1 doz. posture chairs, adjustable
24 chairs, folding, metal
12 waste baskets, metal
6 cans, waste with lid
4 single or 2 double work benches, single type vise on end
1 work bench with storage bins
8 No. 5 modeling wheels with plaster vats
100 lbs. white modeling clay, dry
100 lbs. red firing clay, moist
100 lbs. plaster of paris
10 lbs. glazes, assorted colors and types
1 No. 1 air sprayer for glazing
1 set of modeling tools
1 textbook on pottery making
2 ceramic decorating sets
12 boxwood modeling tools, assorted
1 gross stilts (1, 2, 3, 4, 5)
1 gross triangles (1, 2, 3, 4)
8 shelf props
1 box, 50 cones (06, 05, 012, 0180)
5 lbs. kiln wash
6 brushes for decorating
3 flexible scrapers
1 potters wheel
2 wheel turning tools
10 lbs. banding cement
1 special throwing head set
1 kiln (firing chamber 18"x18"x18")
1 pyrometer

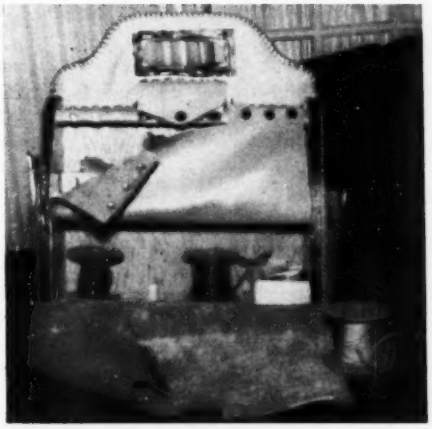
AN OCCUPATIONAL THERAPIST'S CARRYING-CASE

DOROTHY BRADFORD BUZELLE, O.T.R.

Front View of Case



Views of the Alternate Ends of the Case



Front View Showing Two Sections Opened

Back View of Case

The case described in this article was designed as a compromise between the too informal and unwieldy, flat arm-basket and the more business-like brief case, which is easily carried, but the compartments of which render small tools almost inaccessible.

This particular case was designed for a program in which ward visits nearly always included needs for lacing and string and usually involved considerable on-the-spot preparation or finishing which demanded the use of the tools shown. It is approximately fourteen inches high, twelve inches wide and six inches deep. Since there were frequent cash transactions a small box was fastened to the top center of the case. In another program this box might lend itself readily for use as a receptacle for pins or string or other small and easily lost items.

Three small pieces of dowelling, inserted upright on the bottom shelf, are spaced so as to accommodate three 100-yard spools of leather or plastic lacing. The middle shelf is large enough to hold a prescription pad, rubber cement and several small finished or partly finished projects. The small compartment on the right of the lower shelf holds a metal expanding tape measure and a roll of Scotch or adhesive tape.

The over-all leather covering and specially shaped pockets were cut from defective materials previously donated by a large manufacturer. The outside pockets hold, on one end, scissors, modeling tool and pencil; on the other, punch and pliers. Two long pockets at the back are large enough for the top one to hold a notebook and kits or raw material and for the bottom one to hold C-clamps, wood pieces and string. Flaps on the front open

(*Continued on page* 93)

CORRECTIVE BRACING

ERNEST M. FUCHS, O.T.R.
RENATE L. FUCHS, O.T.R.

To maintain results gained by functional occupational therapy, bracing may be prescribed and is supervised by the attending physician. The need for corrective bracing following various forms of therapy has recently been described by Louis N. Rudin, M.D., Daniel J. Cronin, and John S. Croucher, *Journal of the A.M.A.*, October 3, 1953, p. 479.

Adaptability of Erector parts in combination with rubber and leather materials enable the therapist to construct or improvise braces and splints

Figure 1. Patient wearing corrective brace made of Erector parts under supervision of attending physician.

at little cost. Figures 1 and 2 show the more functional type of bracing which we have designed to overcome the typical flexor spasticity in elbow and wrist of the upper extremity in hemiplegia.

The construction of our brace may be understood from Figure 2. It took about 45 minutes to make plus 15 minutes for adjustments. Erector parts used in this brace are listed in the Erector parts catalogue as:

41 Hole Strip No. J	$0.50 Doz.
1/4 x 8-32 Screw No. S 51	$0.10 Doz.
8-32 Square Nut No. N 21	$0.10 Doz.

Following occupational therapy our hemiplegic patients wear this type of brace daily for prescribed short periods. Dorsiflexion can be increased by decreasing the two triangular structures lateral to the wrist.

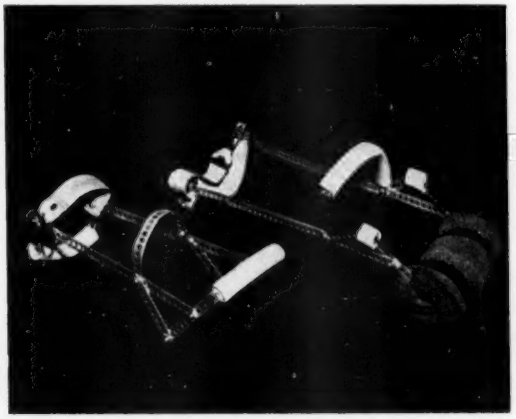


Figure 2. Corrective braces made from Erector parts for hemiplegic patients.

Gentle continuous pressure for dorsiflexion of the wrist and extension of the elbow with gravity assisting is exerted as the entire arm and brace are actively employed to maintain and increase the strength of the extensors. Depending on the prescription, the fingers may be held in grasp position over an adapted rubber padding as shown in Figure 1, or they may be individually corrected by an outrigger or reverse knuckle bender, while the thumb is held in abduction by rubber bands.[1] Also the prescription may call for wearing the brace directly on the arm as shown in Figure 1, or over shirt, sweater, jacket or coat.

The use of Erector parts in general adds a playful note to the otherwise responsible task of building and wearing a brace. The patient may assist with the fastening of screws and/or eyelets, and soon learns to put on and take off his brace under the guidance of the therapist. From the beginning of the treatment, the patient learns to develop skills with the unafflicted hand and is made to feel that he is being helped to help himself.

REFERENCES

1. Silverstein, Frances: "Occupational Therapy and the Hand Splint," *Am. Journ. Occup. Thera.*, VII, 5, 213-222, 1953.

A NEW LOOM[1]

FRANCES M. NICOLL, O.T.R.[2]
JOHN G. BISGROVE, M.D.[3]

During the past few years, great strides have been made in the care and treatment of people with physical disabilities. World War II brought increasing numbers of injured people into our hospitals. The challenge of giving them the best of medical treatment and opportunities for maximum hospital rehabilitation has been great. Those people with spinal cord injuries with resulting paraplegia or quadriplegia, or those with other neuro-muscular disabilities, have composed a group with special problems. Some of the equipment of occupational therapy clinics was not designed so that it could be used to maximum advantage by this special group.

We have regularly seen a large number of patients of this group and have found it necessary to constantly devise new equipment and alter old equipment for their treatment. Over a period of years, weaving has proven to be an interesting and useful activity for many people. But most looms were not designed for use by those with markedly limited use of their upper or lower extremities. Some individual looms were rebuilt but these were not entirely satisfactory and were not widely available.

With the kind help and cooperation of a person[4] experienced in loom-making we have built a new type of loom which has now been in use for almost a year.

It was designed and made especially for use by those with loss of lower extremity function and with complete or limited function of the upper extremities.

This new loom, called the Nicoll Loom, makes it possible for people with paraplegia or partial quadriplegia and those with lower extremity amputations to do weaving on a floor loom made to fit their special needs. A wider range of hand, elbow and shoulder activities can be developed than was possible using smaller table looms. This loom is available in different widths. A narrow one can be used first for light exercise and work. Then the patient may progress to the heavier and wider loom of this same type and make yard goods, rugs and runners of heavier material. This loom has proved to be very effective both for functional and for tonic treatment.

REPORT OF CASES

1. R. D. (Fig. 1) a 22 year old veteran, sustained injury to the spinal cord at level D-10 by shell fragments in August, 1950. He was paraplegic following injury. The paraplegia has persisted with moderate spasticity. The patient was interested in art work and was assigned to the occupational therapy clinic. He became interested in weaving. His desire to weave on something other than a small table loom was satisfied with the introduction of this new loom in our occupational therapy clinic. The patient was very much pleased with the operation of the loom, and was very happy over this satisfying and interesting activity now made possible for him.

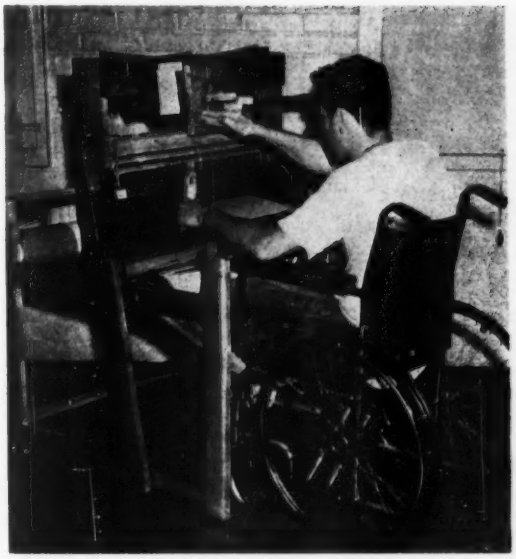


Figure 1

2. M. G. (Fig. 2), a 30 year old veteran, became quadriplegic from poliomyelitis in October, 1949. With prolonged hospitalization and supervised treatment programs there was slow and incomplete return of muscle function. There are now marked residual weaknesses of the extremities; there is only poor to fair strength of the hands and lower extremities and there are marked weaknesses of the elbows and shoulders. He is able to ambulate short distances with much support

1. Reviewed in the Veterans Administration and published with the approval of the Chief Medical Director. The statements and conclusions published by the authors do not necessarily reflect the opinions or policy of the Veterans Administration. The article is from the Physical Medicine Rehabilitation Service, Cushing Veterans Administration Hospital, Framingham, Massachusetts.
2. Chief, Occupational Therapy Section.
3. Chief, Physical Medicine Rehabilitation.
4. Mr. Rollo Purrington, Lane Looms, 39 Main Street, Haydensville, Massachusetts.

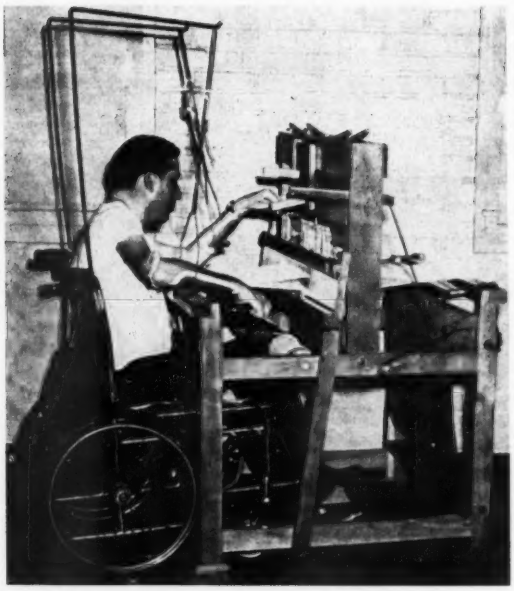


Figure 2

from a walker or special crutches. Arm slings suspended from overhead bars attached to his wheelchair are necessary for the use of his hands; with these, the patient is able to do much of his own eating and certain simple toilet activities. Before his illness the patient had a special interest in textile designing and was very much interested in weaving. He was assigned to the occupational therapy clinic for functional treatment of his upper extremities. In the clinic he started work on the Nicoll loom and was immediately very much pleased with it. He required moderate assistance at first, little or none later on. Strength and joint mobility of the upper extremities have increased, and the patient has found weaving to be an excellent hobby. This should prove to be an excellent activity for helping to maintain upper extremity strength and for pleasure and profit following hospitalization.

APPARATUS

The Nicoll Loom is so constructed that the wheelchair patient can roll under the front beam and can work at the correct height without transferring from his wheelchair to another chair or loom bench. This saves time and effort on the part of the therapist and patient and the wheelchair is often more comfortable than a chair or stool.

The Nicoll Loom is a four harness floor loom operated entirely by hand. The harnesses are raised and lowered by means of hand levers rather than foot treadles. The levers are situated directly in the center of the top frame of the loom. The lever board is made of wood and has slots in which the levers move up and down; there is a wider space at the bottom of the grooves so that each lever can be locked down individually. The handles on the levers are made of wood and can be changed to suit the needs of each patient. Varying resistance or assistance may also be applied through these levers.

To move the woven piece forward for more working space, the patient lifts the handle on the left side of front beam or roller. He then pulls down slightly on the back beam release which is located about half-way up the right center upright of the loom. These front and back beam release handles were put on alternate sides so that they could be worked one after the other, and both are within easy reach of the patient. The front beam release has been made with a double catch so that it can be moved forward a shorter distance if necessary.

The height of the loom can be varied to suit individual needs by placing lifts of different dimensions under the uprights. Lifts that will accommodate most wheelchairs are standard equipment. These can be easily changed as necessary.

An open box arrangement has been made and can be installed on each end of the beater frame to help the patient who has the use of only one arm. This is done so that when the shuttle is thrown it will not fall on the floor.

SUMMARY

1. A new floor loom, entirely hand operated, has been described. It has been used very successfully for the past year in our occupational therapy clinic.

2. This has been found to be extremely satisfactory for functional treatment of the upper extremities, and for tonic treatment.

3. This loom offers a wide range of motion and can easily be adjusted or altered for individual treatment needs.

4. This loom has the advantage of now being available commercially.

5. This offers an excellent medium of post-hospitalization maintenance treatment, both tonic and functional.

ADAPTED EQUIPMENT*

VIOLA W. SVENSSON, O.T.R.
MIRIAM C. BRENNAN, O.T.R.

PREVOCATIONAL TABLE

Table rotates, and has braking device.

All patients are tested for division of vocational rehabilitation review or to determine certain abilities from an orthopedically functional activity.

This table was designed and constructed in our occupational therapy department after visiting numerous factories and observing physical activities that the handicapped person could accomplish.

Method of use:

1. Explain test.
2. Read all directions.
3. Use stop watch.
4. Constantly observe individual.
5. Record any assistance patients may need such as suspension slings, trays in lapboard, etc.
6. If patient too seriously involved, cut test down in performance allowance.

Sections are removable.

Recording:

1. Each tray's result as to time and mistakes, and remarks as to ability are summarized on a printed form chart.
2. One copy of the report is given to the state division of vocational rehabilitation counselor, one kept in the patient's ward chart and one in the occupational therapy department file.

Occupational Therapy Dept. — Prevocational Test
Name **Diagnosis** Polio 1951 **Age** 25
Length of Test 1 hour, incomplete
Rests none **Worked from Table 33" high** XX
Worked from lap

		Min.	Sec.	Errors	Observations
1. Nut and Bolt		15	14		
	In	5	20		Did 10,
2. Screw Boards	Out	4	17		5 each
3. Form Board		1	17		
4. Rivet Assortment		12	28	18	
5. Nuts, Bolts, Plates		2	5		
6. Slug and Lead Assort.		Omitted			
7. Bottle and Cap Assem.		4	34		

SUMMARY

3/3/52:

Patient has scattered involvement of upper extremities. Worked using bilateral chair slings and a left opponens splint. On Tray 1, her fingers tired after working a short time. She had more trouble with the small nuts and bolts than she had with the large ones. Tray 3, she assisted right arm with the left hand to reach the back of the bin. Tray 6 was omitted because of lack of time. Patient is married.

Patient to be retested at a later date.

F. F. Kullberg, O.T.R.

DRAFTING TABLE

The drafting table has been designed and constructed in our occupational therapy department. It has been used for draftsmen in prevocational graded work for the severely handicapped person.

The board is a professional board purchased from a supply house. The chrome legs were shaped in the occupational therapy department from straight lengths of pipe. The turn plate was also constructed in the occupational therapy department.

The table slides sidewise and cornerwise at the slightest pressure of arms or body; it tilts up or

(*Continued on page* 93)

*The seventh of a series of illustrations of apparatus aids toward independent activities as designed and constructed in the occupational therapy department of the New York State Rehabilitation Hospital, West Haverstraw, New York.

Have You Tried . . .

(*Continued from page* 83)

A new development for persons needing side bars to assist them in getting to and from the toilet is the *Self Ease Safety Bathroom Frame* which has just made its appearance on the market. It is a sturdy, rigid, portable, free standing security frame which provides stable, reassuring handgrips and arm rests at the toilet.

The device eliminates the need for costly built-in bars which require anchoring in the tilework. It is heavily chromium-plated on strong one-inch tubular steel and fits attractively into the decor of any bathroom. It is adaptable to all sizes and types of toilets, adjusts in height to fit the person using it and will not slide on any type of floor. For spastic conditions and for those with poor muscular coordination, provision is made for rigidly attaching this unit to the toilet seat fittings.

* * *

The newest series in the Palmer Paint Sales Company products is a Deluxe Craft Master which contains three convases and a choice of twelve different subjects. This set fills a need for one containing more colors and more pictures.

* * *

The S. & S. Leather Company will send a linkit tool free to any occupational therapist requesting it. The tool for assembling link belts is ideal for people that have the use of only one hand. The tool originally sold for $2.50 and is yours for just 30 cents in coins or stamps to cover postage.

* * *

A new, all cotton, disposable towel has been developed by Leshmer Corporation (Hamilton, Ohio) which is flameproof. The towel absorbs more than six times its own weight in grease, oil or water and may be used for wiping, cleaning or polishing. The towels should be most useful in the paint or printing section of an occupational therapy department.

* * *

The new non-acid compound for etching aluminum, Safe-T-Etch, produced by Metal Goods Corporation is a boon to occupational therapists who must have the welfare of the patient always foremost. This etching medium, safe for adults and children, produces beautiful results with none of the old time hazards of acid compounds.

* * *

Do leather products sometimes look the worse for the wear by the time they have been finished by your patients? Schultz Co., 2028 Washington, St. Louis, now has a new polish called "Shine Magic" which renews any leather except suede and any color except white. Also it does not rub off on clothes so can be used on all articles.

Pemco has a line of non-toxic clays and glazes especially designed for schools and hospitals. They fire at cone 010. This lower firing range saves kiln-watching and shortens firing time.

* * *

The J. C. Larson Company is introducing a new Indian type soft sole moccasin made from heavy glove cowhide which comes in several color combinations: cream with a brown trim, red with a white trim and white with a black trim. They are luxuriously soft slippers that come in complete kits for assembling and are very reasonably priced.

* * *

The Thera-Plast Company has developed an important use for GE Silicone Putty. Scientifically processed for therapeutic use only, it becomes an ideal aid in rehabilitation. It can be stretched, squeezed, molded and pulled. It adjusts its resistance to the patient's own progress, and therefore has the added advantage of adaptability to any stage of a pertinent condition. It is approved by the Council on Physical Medicine and Rehabilitation, American Medical Association.

* * *

A new and expanded 40-page edition of "Whittling is Easy with X-acto" is now available for 25c. It contains simple and clear instructions for beginners in the ancient art of whittling and illustrated step-by-step projects for carving interesting figures.

X-acto has also added a new hobby tool. It is a razor saw set which has proved most useful for fine and accurate cross cutting, trimming and notching of metals, wood and plastic. The set contains two razor saw blades of 3/4" and 1" widths and an X-acto universal handle.

* * *

Prepared clay bodies are specifically formulated for school and craft use. Raw, or natural, clays require long, slow drying stages or the pottery piece will blow up in the kiln. Prepared clay bodies, such as Pemco w016 or 2008, dry evenly in the air.

Proper aging is vital to good performance of all clay. When you buy prepared clay bodies in moist form you are sure of having a medium that is properly aged and ready to use.

* * *

Leathercraft Information Service has been resumed by the Robert J. Golka Company. If you have been puzzled as to how some of their more intricate projects are assembled, write in for the loan of a traveling sample, all made up, for your inspection.

A free sample of tipped lacing is also available to everyone in order to show the merit of Golka Slim Tips and the pliers which are used to attach them.

The new potters' wheel offered by Craftool is an excellent one for occupational therapy departments because it is adjustable in height and the foot treadle is interchangeable for either left or right action.

* * *

Wedging is the term used for pressing air pockets out of clay. Air pockets can cause blow-ups in the kiln. Pemco moist clays are thoroughly wedged and ready for use.

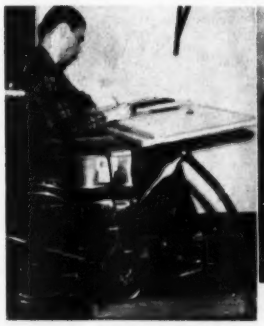
Underglaze colors in liquid form are easier to control and give better results in pottery-making than the old fashioned dry powder form.

* * *

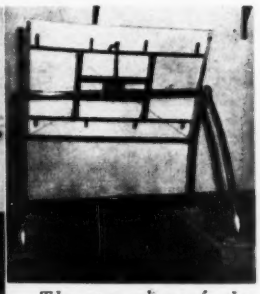
Cleveland Crafts Company is following the modern trend by offering a television lamp kit which consists of a wrought iron frame with legs, reed for weaving the lamp and the electrical attachments.

Drafting Table . . .

(*Continued from page* 91)



The Table in Use



The rear view of the table tilted for good observation.

down by an easily accessible and managed lock handle in front under board.

If an individual is unable to push the parallel up, a sandbag weighing one-half ounce or more on a small pulley attached to the adjusting knob on the parallel will give assistance yet will not pull the parallel out of a set position. Legs of the table can be adjustable by telescoping pipes and pinhole locks.

OT Carrying Case . . .

(*Continued from page* 87)

to give access to bottom shelf only or to top and bottom when desired. The flap on the cash box is snapped independently of the other sections.

Obviously every program would call for individual adaptations of this case. However the basic size and shape would seem to be generally useful and conducive to a minimum expenditure of energy and time for the therapist.

Book Reviews

THE INSIDE STORY
Psychiatry and Everyday Life
Fritz Redlich, M.D.
June Bingham
Jacob Levine, Ph.D.
Published by
Alfred A. Knopf
New York

1953 280 pp.

Reviewed by: Bertha J. Piper, O.T.R.

The compiler (psychiatrist), the author (layman), and the collaborator (psychologist), like the three lenses of the Cinerama, whirl as speedily and entertainingly through the wilderness of dynamic psychiatry, moving confidently through the maze of repressions, anxieties and daydreams and along avenues of human emotions abundantly characterized by popular cartoons, profound literary quotations and witty metaphors. The purpose of this comic-strip procedure into the realms of human behavior is "to convince people of facts about themselves which they didn't know, didn't want to know and didn't want to know that they didn't want to know." (Gertrude Stein's ghost seems to wisping around the author's pen here.)

The reader is introduced to the mysterious forces locked in the depths of personality via "The Key to Laughter: Repressions," a simplified explanation telling why the emotion of laughter is an escape from tension and, without it, why one can be sadly bogged down with frustration. The use of mirth response tests, we are informed, reveal logical explanation for non-laughter as well as for hilarious eruption on the basis of unconscious emotional ramifications.

Interesting and somber descriptions are portrayed on some of the innumerable causes of unconscious tendencies, such as "tit-for-tat," "belief in symbols," "impervious to time," "avoiding pain and suffering"; of the repressed, unchanging, basic urges: "security and dependence, aggression, love," and their varied expression according to cultural background and class; and of how "unconscious defenses," consisting of suppression, forgetting, rationalization, displacement, isolation, regression, sublimation, projection and humor are attempts to purge our stirred up feelings of desolation, fear, guilt and shame.

"Sublimation joins suppression and laughter in being a particularly benign form of unconscious defense and one to which mental patients rarely have access. . . . Like sublimation and suppression, laughter is rare in mental institutions" . . . although "inappropriate laughter may reach such proportions . . . that it becomes a noticeable symptom."

How to judge normality from abnormality is not always a clear-cut issue, regardless of rules and definitions. Do we mean as average, or normal as model, or normal as "well-balanced"? The chapter entitled "Normal and Abnormal People" elucidates quite helpfully on this subject. "The difference between the normal person and the neurotic or character-neurotic (milder cases of 'anti-social personalities') is only one of degree. The difference between the normal person *when awake* and the psychotic or the anti-social personality is more than just a difference of degree. We are aware of reality, intellectually and emotionally, and they are not."

The final chapter glides into a philosophical mood dealing with the combined professional practice and curative methods aimed toward "emotional realignment" by clergymen, psychiatrists, psychotherapists, psychologists and psychiatric social workers, and the potential supportive assistance from the non-professional lay person in alleviating the troubled mind. The author has not overlooked occu-

pational and recreational therapy. Reference is made to this phase of treatment as part of routine hospital care in the case study in Chapter V.

The book contains a glossary with medical and laymen's interpretations, a bibliography of books and films and a list of national agencies for mental health.

MAN AND HIS YEARS
Health Publications Institute, Inc.
Raleigh, North Carolina

311 pps.

Reviewed by: Grace C. Hildenbrand, O.T.R., M.A.

The report of a public forum held in Washington, D.C., and sponsored by the Federal Security Agency. The findings and views reflect the thinking of some 816 participants from all parts of the country. As a participant in the "Creative and Recreational Activities" section, I can say that this was the most unique, the most inspiring and the most informative conference I ever attended.

Man and His Years proudly presents a wealth of material concerning the following problem areas of older citizens:

1. Population changes and economic implications.
2. Income maintenance.
3. Employment, employability and rehabilitation.
4. Health maintenance and rehabilitation.
5. Education.
6. Family life, living arrangements and housing.
7. Creative and recreational activities.
8. Religious programs and services.
9. Professional personnel.
10. Aging research.
11. Community organization.

This book is indeed an eloquent testimony of the sincerity and willingness of the many participants who gave of their experiences so wholly. It should prove a valuable reference volume in the library of anyone interested in serving older folks. I, personally, consider it a "must."

REHABILITATION CENTERS IN THE UNITED STATES
Henry Ridkey
Published by
National Society for Crippled Children and Adults
Chicago, Illinois

1953 $1.00, 128 pp.

Reviewed by: Mary Britton, O.T.R.

A compilation of information submitted by forty rehabilitation centers, December 1-3, 1952, under the sponsorship of the National Society for Crippled Children and Adults and the office of vocational rehabilitation, U. S. Department of Health, Education and Welfare.

Mr. Henry Redkey, consultant on rehabilitation centers, office of vocational rehabilitation, U. S. Department of Health, Education, and Welfare, has done a masterful job in compiling the information presented by the centers and conference committees.

He starts with a general view giving factual information concerning 35 years of center development and poses the need for a definition of a rehabilitation center that expresses the comprehensive concentration of integrated services, but retains a flexibility of concept that can fit the needs of individual communities. He also discusses the considerations in establishing a center, such as determining needs, community interest and possibilities of backing.

The rehabilitation centers are presented in six different classifications to allow some comparison. The classifications are teaching and research centers, centers operated by medical schools and hospitals, community centers with beds, community outpatient centers, insurance centers, and vocational rehabilitation centers. Within each classification charts are used to compare the different centers in such matters as number and type of patients, facilities and personnel. Although there are many similarities between the centers, the charts point up more differences.

Three conference committees report meetings and make recommendations to the continuing committee on integration of services, personnel and professional and community relationships.

A continuing committee was formed to study further the basic needs and practices of rehabilitation centers under the leadership of Mr. William K. Page, Jr., of the Kessler Institute for Rehabilitation.

This book is of interest to anyone contemplating starting a center as well as to those already associated with one.

REPAIR OF FAILING OPPOSITION OF THE THUMB
Lennart Soderberg
The Orthopedic Clinic
Gothenberg Sweden
1953, May, Vol. XXII, Fasc. 3 Pages 237-243

Reviewed by: Margaret Gleave, O.T.R.

An excellent article covering: (1) normal function of the thumb, (2) impaired function from inability or imperfect ability to oppose the thumb, (3) methods of restoring opposition and (4) discussion of arthodesis and tenoplastry.

Diagrams and photographs are well used to illustrate the problems and techniques. Care examples are cited and results compared.

The article should be of interest to all occupational therapists who are faced with the problem of opposition of the thumb.

PERIPHERAL NERVE INJURIES
Webb Haymaker, M.D.
Barnes Woodhall, M.D.
Published by
W. B. Saunders Co., Philadelphia, Pa.
1953, 2nd Edition 272 illus., 333 pp., $7.00

Reviewed by: Frances Stakel Nelson, O.T.R.

In the field of physical rehabilitation few areas require as precise knowledge as that needed in the treatment of peripheral nerve injuries.

All those who found the first edition of Haymaker and Woodhall invaluable will welcome this new edition which is even more helpful and excellent.

The opening section is designed to give a background for the diagnosis of peripheral nerve injuries.

Simple tests used in recognizing peripheral nerve injuries are emphasized in Section II. In addition there is a detailed presentation analyzing the movements tested in neurological examinations and the methods used in such testing.

Classification, causes and symtomatology of peripheral nerve injuries are thoroughly discussed in Section III along with the special tests used to determine more precise localization and degree of nerve damage.

The final section is devoted to diagnosis, not of acute nerve injuries, but of injuries which show atrophy, sensory changes and other tell-tale marks.

As each injury is described, emphasis is placed on the means by which the level of the nerve injury may be detected.

All four sections are profusely illustrated and most of the illustrative material was obtained from the Armed Forces Institute of Pathology assembled during World War II and the Korean conflict.

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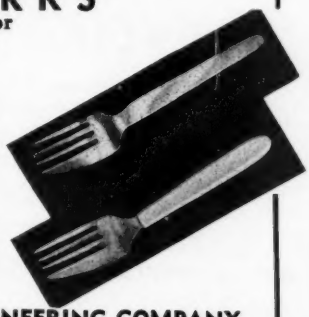

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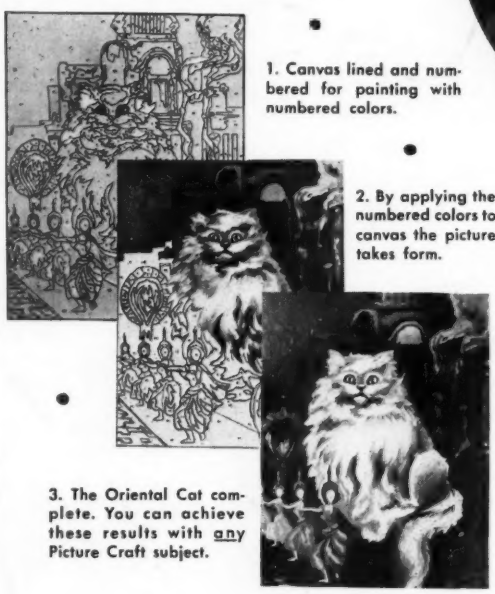

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